DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 331

Registration District No. 791 FEB 25 1941

Primary Registration District No. 1003

Registrar's No. 331

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5953 MINERVA AVE (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community 2 MONTHS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000

(c) City or town ST. LOUIS 617 (If outside city or town limits, write "RURAL")

(d) Street No. 5953 MINERVA 9 (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME CATHERINE B. KELLY

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife JOHN KELLY

6. (c) Age of husband or wife if alive years

7. Birth date of deceased APRIL (Month) 19 (Day) 1870 (Year)

8. AGE: Years 70 Months 8 Days 24 If less than one day hr. min.

9. Birthplace UNKNOWN (City, town, or county) 4 IRELAND (State or foreign country)

10. Usual occupation HOUSE WORK

11. Industry or business HOME

MOTHER FATHER

12. Name MICHAEL O'CONNELL

13. Birthplace (City, town, or county) 4 IRELAND (State or foreign country)

14. Maiden name MARY DAUGHERTY

15. Birthplace (City, town, or county) 4 IRELAND (State or foreign country)

16. (a) Informant Marie Kelly

(b) Address 5953 MINERVA

17. (a) ~~BURIAL~~ REMOVAL (Burial, cremation, or removal) (b) Date thereof 1 (Month) 13 (Day) 41 (Year)

(c) Place: burial or cremation BELLEFONTAINE OHIO

18. (a) Signature of funeral director Cullen & Kelly Co.

(b) Address 1416 N. TAYLOR AVE.

19. (a) JAN 13 1941 (Date received local registrar) (b) J. N. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 12 year 1941 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 7, 1940, to Jan 12, 1941 that I last saw her alive on Jan 12, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac Failure	12 hrs
Due to Lobar Pneumonia	5 days
Due to 108	
Other conditions Fed chronic & nephritis (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature John D. Poe (M. D. or other)

Address 1402 Hodiamon av Date signed 1/13-41

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed James A. Lammers

Licensed Embalmer No. 4142

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2
-1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 331 9

Registration District No. 791NN, 125 Primary Registration District No. 1003 Registrar's No. 331

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

BOWENA MOORE

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Catherine B. Kelley
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	70	8	24	hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 5-14-41 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 12
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature John D Roe (M. D. or other)
Address Date signed

SUPPLEMENTARY

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.