

No. 27
1-4-41
-17-39
X26390

FILED OCT 7 1941

Registration District No. 754 FILED OCT 7 1941

Primary Registration District No. 200

Registrar's No. 1942

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Koch

(c) Name of hospital or institution: Robert Koch Hospital
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 437 days
(Specify whether years, months or days)

In this community 45 years, 3 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis

(c) City or town St Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2425 A N. Harrison
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EDWARD KELLY

3. (b) If veteran, name war SWO

3. (c) Social Security No. 499-07-0195

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Margaret Kelly nee Craded

6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased May 21 1896
(Month) (Day) (Year)

8. AGE: Years 45 Months 3 Days 26

If less than one day hr. min.

9. Birthplace St Louis 6 Mo
(City, town, or county) (State or foreign country)

10. Usual occupation odd jobs

11. Industry or business _____

12. Name John Kelly

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

14. Maiden name Mary Farrell

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

16. (a) Informant Hospital Record

(b) Address Robert Koch Hospital Koch Mo

17. (a) Burial (b) Date thereof 9-19-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic Cemetery

18. (a) Signature of funeral director Chicago Funeral Home

(b) Address 4228 So. 1st St. St. Louis

19. (a) SEP 17 1941 (b) B. McFarber
(Date received for registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 16
year 1941 hour 8 minute 50 A.M.

21. I hereby certify that I attended the deceased from July 6 1940 to Sept 16 1941;
that I last saw him alive on Sept 16 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis

Due to T.B.

Due to _____

Other conditions Bronchial asthma
(Include pregnancy within 3 months of death)
Retrivial hernia

Major findings Of operations _____

Of autopsy _____

Duration 20 months plus

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? _____

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Frank Cohen (M. D. or other) MD

Address Robert Koch Hospital Date signed Sept 16/41

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

MOTHER FATHER

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

Edwin M. Herriott

Licensed Embalmer No.....

3024

P. O. Address.....

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

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