

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Firmin Desloge Hosp. 0
(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

3: (a) PRINT FULL NAME PHILLIP D. SKELLY

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lucille Skelly 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 10 10 1905
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>36</u>	<u>7</u>	<u>14</u>	hr. _____ min. _____

9. Birthplace St. Louis, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Assembler Ford Motor Co.

11. Industry or business Ford Motor Co.

12. Name Michael Skelly

13. Birthplace St. Louis, Missouri. 0 1 1
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Bojart

15. Birthplace Belgium 14
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lucille Skelly (wife)

(b) Address 2819 Blair Ave.

17. (a) Burial (b) Date thereof 5-27-1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Calvary Cemetery

18. (a) Signature of funeral director SULLIVAN BROTHERS

(b) Address 2849 No. Euclid Ave.

19. (a) MAY 25 1942 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 2819 Blair Ave. (If rural, give location)
(e) Citizen of foreign country? 0 26 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24
year 1942 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from 5-11-42
_____ 19____ to 5-24 _____ 1942
that I last saw him alive on 5-24-6:45 PM. _____ 1942
and that death occurred on the date and hour stated above.

Immediate cause of death

Post operative Bronchopneumonia
Due to Lobectomy - left lower lobe of lung

Due to Cystic disease of lung
Other conditions no malady injury
(Include pregnancy within 3 months of death)

Major findings:

Of operations Cystic degeneration of left lower lobe
Of autopsy Bronchopneumonia

Duration

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) (e) Means of injury _____

23. Signature Louis F. Moore (M. D. or other) _____
Address Desloge Hospital Date signed _____

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 Albert Mayfield
Licensed Embalmer No. 3077
P. O. Address St. Louis Mo.

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16674
Registrar's No. 4528

Registration District No. _____

Primary Registration District No. _____

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 Fernier Desloge Hosp
(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)

3. (a) PRINT FULL NAME Phillip P Kelly
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Oct 10- 1903
(Month) (Day) (Year)

8. AGE: Years 36 Months 7 Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) J. P. Prudek (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County _____
(c) City or town St Louis (If outside city or town limits, write "RURAL")
(d) Street No. 2819 Blain ave (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day _____
year 1942 hour _____ minute 45 P.

21. I hereby certify that I attended the deceased from _____
_____ 19____
that I have seen him/her alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

S-16674