

FILED NOV 6 1942

Registration District No. 447

Primary Registration District No. 3008

Registrar's No. 339

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

1. PLACE OF DEATH:

(a) County O'Fallon

(b) City or town Fulton

(c) Name of hospital or institution: State Hospital No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 weeks 15 days
(Specify whether)

In this community senior
years, months or days

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. St Louis City Hospital
(If rural, give location)

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

3. (a) PRINT FULL NAME Bush Kelley

3. (b) If veteran, name war DK.

3. (c) Social Security No. DK.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Death day 16
year 1942 hour 8 minute 30 M.

21. I hereby certify that I attended the deceased from Oct 10 - 1942
1942 to Oct 16 1942
that I last saw him alive on Oct 16 1942
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race negro

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

6. (b) Name of husband or wife DK

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

7. Birth date of deceased March 2 1892
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage

Duration _____

8. AGE: Years 50 Months 7 Days 14

If less than one day _____ hr. _____ min.

Due to _____

Due to _____

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

Other conditions (Include pregnancy within 3 months of death) 30!

10. Usual occupation Suburban

11. Industry or business _____

MOTHER FATHER { 12. Name Martin Kelley

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

14. Maiden name Liza Taylor

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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

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

(b) Date of occurrence _____

17. (a) Removal (b) Date thereof 10 22 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia MO

(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? _____

18. (a) Signature of funeral director J. O. Roberts

(b) Address Columbia MO

While at work? _____ (Specify type of place)

(e) Means of injury _____

19. (a) 10-22-42 (b) Jour. Moskoff
(Date received local registrar) (Registrar's signature)

23. Signature P. F. Puer (M. D. or other) MD

Address Fulton MO Date signed 10/16/42

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 with the above constitutes grounds for revocation of license.)

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