

S. No. 2
M-2-43
5-17-39
I X3567

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12365**

ED APR 23 1943

818

Primary Registration District No. **1003**

Registrar's No. **3511**

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:
DePaul Hospital
(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 **Missouri** (b) County.....

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

(d) Street No. **5150 Terry Ave.**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Thomas J. Kiely**

3. (b) If veteran, name war..... 3. (c) Social Security No. **none**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Alice Kiely** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **January 3 1883**
(Month) (Day) (Year)

8. AGE: **(A) 60** Years **3** Months **5** Days If less than one day..... hr. min.

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

10. Usual occupation **Merchant**

11. Industry or business.....

12. Name **Thomas Kiely**

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

14. Maiden name **Martha Wotton**

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

16. (a) Informant **Mrs. Ella Dumont**
(b) Address **5811 Cabanne**

17. (a) **Burial** (b) Date thereof **4/12/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Albert H. Hoppe Inc.**
(b) Address **4700 Washington Blvd.**

19. (a) **APR 14 1943** (b) **J. J. Pedrick**
(Data received from Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **8**
year **1943** hour **12** minute **25** M.

21. I hereby certify that I attended the deceased from **2-15**
1943 to **4-8-43** 19.....
that I last saw him alive on **4-8-43** 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Thrombosis
Diabetes Mellitus
Due to **Atherosclerosis**

Other conditions (Include pregnancy within 3 months of death) **W**

Major findings:
Of operations.....
Of autopsy **none**

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 **W**

23. Signature **J. J. Pedrick** (M. D. or other) **W.D.**
Address **5899 Delmar** Date signed **4/9/43**

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

3517
ETC

3517
ETC

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..... *J. Allen Davis*.....

Licensed Embalmer No..... *4053*.....

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.