

REG NOV 20 1943 18

Registration District No.

Primary Registration District No. 1000

Registrar's 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:
Mo Baptist Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 Days
In this community 10 Days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Delia 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 Widowed
6. (b) Name of husband or wife Lawrence 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Mar 28 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 7 10 hr. min.

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

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Not Ascertainable

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

14. Maiden name Unknown

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

16. (a) Informant Lawrence Kelly

(b) Address 5068 Minerva Ave

17. (a) Burial (b) Date thereof 10/11/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cent

18. (a) Sign of Registrar Harrison & Sheahan Und Co

(b) Address 4415 Washington Blvd

19. (a) NOV 10 1943 (b) J. J. Bredack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 17 6
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5068 Minerva
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country Ireland

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 8th
year 1943 hour 7:00PM minute M.

21. I hereby certify that I attended the deceased from Oct 29th
....., 1943, to Nov 8th 1943
that I last saw her alive on Nov 8th 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Bronchial / Pneumonia

Due to 83

Other conditions Cerebral Hemorrhage
(Include pregnancy within 3 months of death)

Major findings: Chronic Cystitis
Of operations Catarhal

Of autopsy Same as above

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 John B. O'Neill (M. D. or other)
Address 634 N. Grand Date signed 11/9/43

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

MOTHER FATHER

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

Dr. Small
6347 Howard

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 W. Wilkins
Licensed Embalmer No. 3575
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.

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