

FILED FEB 27 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

535
State File No. _____
337
Registrar's No. _____

Registration District No. 318

Primary Registration District No. 1003

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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days
(Specify whether
In this community 30 years
years, months or days)

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") 12
(d) Street No. 3005 Pine St. (rear)
(If rural, give location) 991
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 9
year 1944 hour 11 minute 10 A. M.
21. I hereby certify that I attended the deceased from December
27, 1943 to January 9, 1944;
that I last saw him alive on January 9, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration
Hypertension Unk.
Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
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 J. E. Bradek (M. D. or other) _____
Address 2601 N. W. Lattin Date signed 1/11/44

3. (a) PRINT FULL NAME John Kellon

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years abt 65 Months _____ Days _____ If less than one day br. _____ min. _____

9. Birthplace Miss. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name John Kellon Sr

13. Birthplace Mississippi 1
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace Miss 1
(City, town, or county) (State or foreign country)

16. (a) Informant Elizabeth Johnson

(b) Address 3677 Cook Ave Hill

17. (a) ~~Shipped~~ Removal (b) Date thereof Jan 12-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Little Rock Ark

18. (a) Signature of funeral director Atticus Deo

(b) Address 3644 Finney Ave
JAN 12 1944
19. (a) Date received local registrar _____ (Registrar's signature) J. E. Bradek

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.....

Louis V. Atkins

Licensed Embalmer No.....

2842

P. O. Address.....

3644 Finley

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.