

FILED JUL 15 1948

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4552 Chouteau St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community Life (Specify whether
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. 4552 Chouteau
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Catherine M. Kelly

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife J. Robert Kelly 6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased December 1 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 7 3 .hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER { 12. Name Peter Connell
13. Birthplace Ireland (City, town, or county) (State or foreign country)
14. Maiden name Ellen Sheridan
15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant Marie O'Reilly
(b) Address 4552 Chouteau St.

17. (a) Burial (b) Date thereof 7/7/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Oscar J Hoffmeister
(b) Address 4016 Chippewa St. Und. CB

19. (a) JUL 6 1948 J. F. Bredeek
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4
year 1944 hour 11 minute 45 pm.

21. I hereby certify that I attended the deceased from March 1924 to July 4 1944
that I last saw h. alive on July 4 1944
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy cerebral
Duration 1 month
Due to Chronic Degenerative Hypertension

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?

(Specify type of place) While at work? (c) Means of injury.....

23. Signature J. P. Johnson (M. D. or other) MD
Address 6233 Westchester Date signed July 6 1948

101 11 35

JUL 6 1944

Emb Sep Cert filed

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 the above constitutes grounds for revocation of license.)

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