

FILED SEP 18 1944

Registration District No. **317**

Primary Registration District No. **3069**

Registrar's No. **1877**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Richmond Heights**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's Hospital **0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2-wks.**
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Kathleen P. Kiely**

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

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

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

7. Birth date of deceased **July 30, 1944**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 1 11 hr. min.

9. Birthplace **St. Louis Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nil**

11. Industry or business

MOTHER FATHER { 12. Name **John J. Kiely**
13. Birthplace **St. Louis Mo. 0**
(City, town, or county) (State or foreign country)
14. Maiden name **Ethel Crow**
15. Birthplace **St. Louis Mo. 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. John J. Kiely**
(b) Address **7359 Amherst Ave.**

17. (a) **Burial** (b) Date thereof **9-11-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Galvar**
18. (a) Signature of funeral director **Charles J. Connelly**
(b) Address **3840 Lindell Blvd.**

19. (a) **SEP 12 1944** (b) **C. J. Connelly**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis 96**
(c) City or town **University City 5**
(If outside city or town limits, write "RURAL")
(d) Street No. **7359 Amherst Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... **1**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **11th.**,
year **44** hour **3** minute **15 a.m.**

21. I hereby certify that I attended the deceased from **Aug 28**
....., 19....., to **Sept 10, 1944**
that I last saw **alive** on **Sept 10, 1944**
and that death occurred on the date and hour stated above

Immediate cause of death **malnutrition** Duration **5 wks**
Searcher of records

Due to **prematurity**
Infection

Due to.....
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy..... **1190**
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?..... (a) Means of injury.....
23. Signature **John J. Connelly** (M. D. number).....
Address **7359 N.Y.** Date signed **9-11-44**

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

96
23

STATEMENT BY LICENSED EMBALMER

Not

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.