

FILED OCT 25 1945  
318

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1003

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: St. Louis Children's Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days, 12 hrs.  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days \_\_\_\_\_

3. (a) PRINT FULL NAME Walter Lee Kelley, II

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced. 0

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

7. Birth date of deceased October 11, 1945  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 4 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Walter W. Kelley

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

14. Maiden name Kenna Lee Dodson

15. Birthplace Dont Know Mo. A  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Walter Kelley

(b) Address 3935 McPherson Ave.

17. (a) Burial (b) Date thereof 10-16-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old St. Marcus Cent.

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd. S.

19. (a) OCT 16 1945 J. F. Brebeck  
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10  
(c) City or town Centralia  
(If outside city or town limits, write "RURAL") N.R.O.  
(d) Street No. \_\_\_\_\_ (If rural, give location) \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 15  
year 1945 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from October 12, 1945 to October 15, 1945;  
that I last saw him alive on October 15, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death: congenital gastrointestinal anomalies with omphalocele

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: 151  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 0

23. Signature R. J. Bl. Hae (M. D. or other) \_\_\_\_\_

Address 100 So. Kingshighway Date signed \_\_\_\_\_

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

100  
17  
9

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 mat.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed Stanley Marshall.....

Licensed Embalmer No. 2868.....

P. O. Address 3840 Lindell.....

**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.**