

S. No. 2
-12-45
5-17-39
I X47070

FILED JUL 1 1947

Registration District No. _____ Primary Registration District No. **6048**

1. PLACE OF DEATH:

(a) County **St. Charles**

(b) City or town **O'Fallon, Missouri**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Mary's Institute
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **5 1/2 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Charles 92**

(c) City or town **O'Fallon, Missouri**
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Sister M. Laetitia Kelly**

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

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **June 5 1876**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	71	0	12	_____ hr. _____ min.

9. Birthplace **Crete Nebraska**
(City, town, or county) (State or foreign country)

10. Usual occupation **Teacher - religious**

11. Industry or business _____

MOTHER FATHER

12. Name **Thomas Kelly**

13. Birthplace **Ireland 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary McInerney**

15. Birthplace **Ireland 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Sister M. Dominica**

(b) Address **St. Mary's Institute, O'Fallon**

17. (a) Burial (Burial, cremation, or removal) _____ (b) Date thereof **June 20, 1947**
(Month) (Day) (Year)

(c) Place: burial or cremation **O'Fallon, Missouri**

18. (a) Signature of funeral director **H.C. Dallenmeyer & Son**

(b) Address **St. Charles, Mo.**

19. (a) **June 20-47** (b) **E.A. Kuehler**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **17**
year **1947** hour **1:00** minute **A** M.

21. I hereby certify that I attended the deceased from **March 12**, 19____, to **17 June**, 19**47**
that I last saw her alive on **10 June**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of breast with metastasis to lung**

Due to _____

Due to _____

Other conditions (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 _____

23. Signature **L.B. Behm** (M. D. _____)
Address **O'Fallon Mo.** Date signed **18 June 47**

Duration **15 mo**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUN 27 1947

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.....

Joseph I Landoct

Licensed Embalmer No. *4189*

P. O. Address *St Charles*

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.