FILED AUG 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24907

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6755

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS,
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. ANTHONY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission):
a. STATE MISSOURI
b. COUNTY ST. LOUIS, 41
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. ANN'S VILLAGE
d. STREET ADDRESS (If rural, give location) NR. 10412 SAN CARLOS LANE

3. NAME OF DECEASED (Type or Print)
a. (First) JAMES
b. (Middle) KELLY
c. (Last) HOING

4. DATE OF DEATH (Month) (Day) (Year) AUG 2, 1949

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE
8. DATE OF BIRTH 12/12/46
9. AGE (In years last birthday) 2 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) ST. LOUIS, MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME JOHN MELVIN HOING
13b. MOTHER'S MAIDEN NAME AGNES PATRICIA KELLY
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT'S SIGNATURE OR NAME JOHN MELVIN HOING — ADDRESS 10412 SAN CARLOS LANE

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Ant. Poliomyelitis. Bulbo Encephalytic.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 36

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 0800

22. *I hereby certify that I attended the deceased from* July 31, 1949, *to* Aug. 2, 1949, *that I last saw the deceased alive on* Aug. 2, 1949, *and that death occurred at* 10:45 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M. Cook M.D.
23b. ADDRESS St Anthony Hosp.
23c. DATE SIGNED 8-3-49

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 8/5/49
24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY
24d. LOCATION (City, town, or county) (State) ST. LOUIS,

DATE REC'D BY LOCAL REG. AUG 3 1949
REGISTRAR'S SIGNATURE J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE STROOT - CARROLL — ADDRESS 4600 NATURAL BRIDGE

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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