

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 90

No. 300  
10.48

FILED JAN 21 1950

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 90

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, write RURAL and give town) ST LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) 4170 TOWN NORMANDY	
d. FULL NAME OF HOSPITAL OR INSTITUTION DE PAUL HOSPITAL		d. STREET ADDRESS (If rural, give location) NR VILLA ST LOUISE	
3. NAME OF DECEASED a. (First) SISTER REGINA (ANN CATHERINE) KELLY (Type or Print)		4. DATE OF DEATH JAN. 3, 1950 (Month) (Day) (Year)	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH APRIL 3, 1877 / 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS		10b. KIND OF BUSINESS OR INDUSTRY SISTERS OF CHARITY	11. BIRTHPLACE (State or foreign country) ST. LOUIS, MO
13a. FATHER'S NAME JOHN KELLY		13b. MOTHER'S MAIDEN NAME MARY KNOLL	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS SISTER LEONIE, VILLA ST LOUIS	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion Antecedent Causes Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Coronary Sclerosis 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.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) 940	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201	
22. I hereby certify that I attended the deceased from Jan 1, 1950, to Jan 3, 1950, that I last saw the deceased alive on Jan 3, 1950, and that death occurred at 7:00 p.m., from the causes and on the date stated above.			
23a. SIGNATURE N.B. Moran (Degree or title) M.D.		23b. ADDRESS 539 N. Grand St. Louis	23c. DATE SIGNED 1/4/50
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JAN 5, 1950	24c. NAME OF CEMETERY OR CREMATORY MARILLAC	24d. LOCATION (City, town, or county) (State) NORMANDY MO.
DATE REC'D BY LOCAL REG. JAN 5 1950	REGISTRAR'S SIGNATURE J. Hasatka	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cullen & Kelly 4386 LINDELL BLVD.	

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 James A. Lemmers

Licensed Embalmer No. 4142

P. O. Address St. Louis

**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.