

FILED FEB 27 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6529

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1045**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis 2079	
c. LENGTH OF STAY (in this place) 4 Weeks		d. STREET ADDRESS (If rural, give location) 4605 San Francisco Avenue, 15	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital		7	

3. NAME OF DECEASED (Type or Print) Thomas	a. (First)	b. (Middle) S.	c. (Last) Kell	4. DATE OF DEATH (Month) (Day) (Year) Feb. 2nd, 1952
--	------------	--------------------------	--------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 6th, 1875	9. AGE (In years last birthday) 76	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) Retired Motorman	10b. KIND OF BUSINESS OR INDUSTRY Public Service Co.	11. BIRTHPLACE (State or foreign country) Carterville, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
--	--	---	--

13a. FATHER'S NAME Porter Alexander Kell	13b. MOTHER'S MAIDEN NAME Rosalie Cunningham	14. NAME OF HUSBAND OR WIFE Anna K. Kell nee Foehr.
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Anna K. Kell, 4605 San Francisco Avenue, 15	ADDRESS 4605 San Francisco Avenue, 15
--	--	---	---

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Permanently
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerotic heart disease		
	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 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)
--	--	---

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? H200
--	--	---

22. I hereby certify that I attended the deceased from **Nov. 1947** to **Feb 2, 1952**, that I last saw the deceased alive on **Jan 1, 1952**, and that death occurred at **7:40 AM.**, from the causes and on the date stated above.

23a. SIGNATURE Norman J. ...	(Degree or title) MD	23b. ADDRESS 634 W. ...	23c. DATE SIGNED 2/2/52
--	--------------------------------	-----------------------------------	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2/5/52	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	24d. LOCATION (City, town, or county) (State) Saint Louis County, Missouri
---	----------------------------	---	--

DATE REC'D BY LOCAL REG. FEB 4, 1952	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Calvin F. Feutz	ADDRESS 4828 Natural Bridge 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed Ralph C. Ferguson

Licensed Embalmer No. 4278

P. O. Address St. Louis

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

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