

FILED JUN 16 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18183

(State File No.)

4950

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission). a. STATE Mo. 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 St. Louis 2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 16 3803 Humphrey St.	

3. NAME OF DECEASED (Type or Print)	a. (First) DANIEL	b. (Middle) J.	c. (Last) KELLY	4. DATE OF DEATH (Month) (Day) (Year) May 27 1952
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sep't. 6, 1873	9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 78	10. UNDER 1 YEAR 4	11. UNDER 2 HRS. U.S.A.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationery Engineer-Scullin Steel	10b. KIND OF BUSINESS OR INDUSTRY Co. Ireland	11. BIRTHPLACE (State or foreign country) 4	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James Kelly	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Jane Kelly
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Daniel J. Kelly Jr. 3803 Humphrey
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Several months
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chromia of Calcium		
	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. Arterio Sclerotic Heart Dis.		

19a. DATE OF OPERATION 5-26-52	19b. MAJOR FINDINGS OF OPERATION Ca of Calcium	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY. (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 153X
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22. I hereby certify that I attended the deceased from **1-23-** 19**35**, to **5-27-** 19**52**, that I last saw the deceased alive on **5-27-** 19**52**, and that death occurred at **12:45 P.** m., from the causes and on the date stated above.

23a. SIGNATURE Carl H. Smith M.D. (Degree or title)	23b. ADDRESS Humboldt Bldg.	23c. DATE SIGNED 5-29-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 30, 1952	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 29 1952 J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl
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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 _____

Edwin M. Derrma

Licensed Embalmer No. 3024

P. O. Address _____

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.