

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43554

No. 300-10-48
ED JAN 10 1953

State File No. 11347

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL, and give town) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		c. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN St. Louis 2179	
3. NAME OF DECEASED (Type or Print) HATTIE		d. STREET ADDRESS (If rural, give location) 4016 De Tonty Avenue	
a. (First) b. (Middle) c. (Last) KELLING		4. DATE OF DEATH DECEMBER 8, 1952	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 7, 1862
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At home	9. AGE (In years last birthday) 90
11a. FATHER'S NAME John Lesley		11b. MOTHER'S MAIDEN NAME Mary Scott	11. BIRTHPLACE (City and State or Foreign Country) Crawfordsville, Ind.
12. CITIZEN OF WHAT COUNTRY?		13. NAME OF HUSBAND OR WIFE Edward Kelling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Anna Campbell		ADDRESS 4016 De Tonty Ave.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CVA - thrombosis		DUE TO (b) CAS			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. LLL pneumonia					

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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 334X	

22. I hereby certify that I attended the deceased from 12-6-52, 19, to 12-8-52, 19, that I last saw the deceased alive on 12-8-52, 19, and that death occurred at 7:30A m., from the causes and on the date stated above.

23a. SIGNATURE John W. Wallace M.D.		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 12-8-52	
24a. BURIAL, CREMATION, REMOVAL		24b. DATE Dec. 10/52		24c. NAME OF CEMETERY OR CREMATORY Carlyle, Illinois	
24d. LOCATION (City, town, or county) (State)					

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE DEC 9 1952 J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Weick Bros. 2201 So. Grand Blvd.	
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(Licensed Embalmer's Statement on Reverse Side)

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

JUL 28 1953

JAN 15 1953

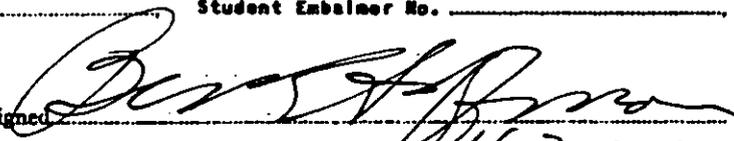
STATEMENT BY LICENSED EMBALMER

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
Student Embalmer

Student Embalmer No. _____

Signed 

Licensed Embalmer No. 4366

P. O. Address Illinois

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.