

FILED APR 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13651**
3088

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 death) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give county) OR TOWN St. Louis, Missouri.		c. LENGTH OF STAY (If this place) 41 days		c. CITY OR TOWN University City,		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital.				e. STREET ADDRESS (If rural, give location) #7649 Lynn Avenue.			
3. NAME OF DECEASED (Type or Print)		a. (First) THOMAS		b. (Middle) SHERMAN		c. (Last) KELL.	
4. DATE OF DEATH		(Month) April		(Day) 4,		(Year) 1954.	
5. SEX Male.		6. COLOR OR RACE White.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married.		8. DATE OF BIRTH Dec 3, 1903	
9. AGE (In years last birthday) 50.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) Sales Man., Food Equipment Corp.,				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri.	
13a. FATHER'S NAME Thomas Scott Kell.			13b. MOTHER'S MAIDEN NAME Anna Foehr.			14. NAME OF HUSBAND OR WIFE Robbie L. Kell.	
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. 488-10-0199		17. INFORMANT'S SIGNATURE OR NAME Mrs Robbie Kell, ADDRESS 7649 Lynn Avenue.			
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) Coronary thrombosis		ANTECEDENT CAUSES				2 mo	
*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 (b) coronary insufficiency					
		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) 4201			
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? _____			
22. I hereby certify that I attended the deceased from Feb , 1954, to April 5 , 1954, that I last saw the deceased alive on April 5 , 1954, and that death occurred at 2:45 p.m., from the causes and on the date stated above.							
23a. SIGNATURE Dr. W. O. Missey Jr. (Degree or title) MD				23b. ADDRESS 634 1/2 Grand		23c. DATE SIGNED 4/6/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal.		24b. DATE 4/6/54.		24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery.		24d. LOCATION (City, town, or county) (State) #7800 St. Charles Rock Road.	
DATE REC'D BY LOCAL REG. APR 6 1954		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE W. R. Lupton & Sons, ADDRESS #7233 Delmar Bly'd.			

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

82: 1-5234,
9-10:30 A.M.

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.....
Signature of Student Embalmer

Signed *Clarence H. Murr*.....

Licensed Embalmer No. *40*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.