

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15967

State File No.

2034

FILED MAY 28 1954

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Miami	
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City	c. LENGTH OF STAY (in this place) 5 days	c. CITY (If outside corporate limits, write RURAL and give township) Bucyrus	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS (If rural, give location) 815⁰ 8	

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Edward c. (Last) Kelly			4. DATE OF DEATH (Month) (Day) (Year) May 6 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 21, 1886		9. AGE (in years last birthday) 68 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) Depot Agent		10b. KIND OF BUSINESS OR INDUSTRY Mo. P. R. R.	11. BIRTHPLACE (State or foreign country) Sullivan, Ill.		12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME John Wm. Kelly		13b. MOTHER'S MAIDEN NAME Sophia Kidwell		14. NAME OF HUSBAND OR WIFE Edith Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Edith B. Kelly Bucyrus, Kans.	

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 48 hrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardio-vascular disease			420
	DUE TO (c) _____			4434
	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)		
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?		

22. I hereby certify that I attended the deceased from May 2, 1954, to May 6, 1954, that I last saw the deceased alive on May 5, 1954, and that death occurred at 10:07 AM, from the causes and on the date stated above.

23a. SIGNATURE J. B. Castles M.D. (Degree or title) 0		23b. ADDRESS 1002 Arroyo Blvd N6 Mo		23c. DATE SIGNED 5-6-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5-6-54	24c. NAME OF CEMETERY OR CREMATORY -	24d. LOCATION (City, town, or county) (State) Spring Hill Kansas	

DATE REC'D BY LOCAL REG. 5-6-54	REGISTRAR'S SIGNATURE Sauldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Grace Patterson Spring Hill
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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.....

Roy Bruce

Licensed Embalmer No. *1989*

P. O. Address *Sardner, Mo.*

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.