

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24793

318

1003

Registrar's No. 6498

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>St. Louis, Mo.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Mo.</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis, Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) _____		• STREET ADDRESS (If rural, give location) <u>4443 Itaska</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4443 Itaska</u>		<u>15</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Matthew</u> b. (Middle) <u>S.</u> c. (Last) <u>Kiely</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7/14/54</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>October 1, 1880</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aloe Optical</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>	

13a. FATHER'S NAME <u>Matthew S. Kiely</u>		13b. MOTHER'S MAIDEN NAME <u>Nonie Kiely</u>		14. NAME OF HUSBAND OR WIFE <u>Nonie Kiely</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Matthew Kiely</u>	
				ADDRESS <u>5476 Jennings Rd.</u>	

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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senility</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Malnutrition</u> DUE TO (c) <u>Arterio Sclerosis</u>		
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>4300</u>	
22. I hereby certify that I attended the deceased from <u>July 3, 1954</u> , to <u>July 14, 1954</u> , that I last saw the deceased alive on <u>July 14, 1954</u> , and that death occurred at <u>7 am.</u> , from the causes and on the date stated above.					

23a. SIGNATURE <u>John V. Lawrence M.D.</u>		23b. ADDRESS <u>3720 Washington</u>		23c. DATE SIGNED <u>7-14-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>7/17/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	
				24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	

DATE REC'D BY LOCAL REG. <u>JUL 16 1954</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sullivan's Euclid at St. Louis</u>	
				ADDRESS <u>Sullivan's Euclid at St. Louis</u>	

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.....  
Signature of Student Embalmer

Signed..... *W W Wilkins*

Licensed Embalmer No... *35*

P. O. Address *M. Lane*

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.