

FILED MAR 31 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9811**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2215**

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 OR TOWN St. Louis)		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION: 4239 Linton Ave.		e. STREET ADDRESS (If rural, give location) 4239 Linton Ave.					
3. NAME OF DECEASED (Type or Print) a. (First) Gertrude Lillian b. (Middle) Kelly c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Mar. 8. 1955				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 29. 1888	9. AGE (In years last birthday) 66	f. UNDER 1 YEAR Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and State or Foreign Country) Bridgeton, Mo.			
13a. FATHER'S NAME Henry Herbst		13b. MOTHER'S MAIDEN NAME Anna Ernst		14. NAME OF HUSBAND OR WIFE John J. Kelly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 496-22-8135		17. INFORMANT'S SIGNATURE OR NAME ADDRESS John J. Kelly 4239 Linton Ave.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia 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. Chr Myocarditis				INTERVAL BETWEEN ONSET AND DEATH Mar. 5-55	
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? 491x		22. I hereby certify that I attended the deceased from Mar 6, 1955 , to Mar 8, 1955 , that I last saw the deceased alive on Mar 8, 1955 , and that death occurred at 1:55 pm. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Charles M. Smith M.D.		23b. ADDRESS 2739 N. Grand		23c. DATE SIGNED Mar. 10 1955			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/11/55		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery			
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.A. Stock, 2117 E. Grand Ave.					
DATE REC'D BY LOCAL REG. MAR 10 1955		REGISTRAR'S SIGNATURE Charles M. Smith M.D.					

WRITE PLAINLY—USING UNFAADING 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.....
Frank A. Moore

Licensed Embalmer No. 309

P. O. Address 2117 E. 12

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.