

FILED AUG 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

23966

318

PRIMARY REG. DIST. NO. 1003

5627

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 30 yrs		c. CITY OR TOWN St. Louis		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: I419 A.N. Spring Ave.				e. STREET ADDRESS (If rural, give location) I419 A.N. Spring Ave.					
3. NAME OF DECEASED (Type or Print) a. (First) Mary			b. (Middle)		c. (Last) Kelley		4. DATE OF DEATH (Month) (Day) (Year) June 27, 1955.		
5. SEX Female 3		6. COLOR OR RACE Col.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2		8. DATE OF BIRTH Sept, 29, 1894		9. AGE (In years last birthday) 60 IF UNDER 1 YEAR Months 8 Days 28 IF UNDER 1 HR. Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Columbus, Miss.			12. CITIZEN OF WHAT COUNTRY? USA.	
13a. FATHER'S NAME Sisus Gambleson			13b. MOTHER'S MAIDEN NAME Irene Thomas			14. NAME OF HUSBAND OR WIFE None			
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. Nil		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Louies Frye I419 A.N. Spring 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cardio Renal Vasculardisease</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Hypertension</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
19a. DATE OF OPERATION <i>none</i>		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>none</i>		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) <i>none</i>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>none</i>		442X			
22. I hereby certify that I attended the deceased from <i>5-31, 1955</i> , to <i>6-27, 1955</i> , that I last saw the deceased alive on <i>6-27, 1955</i> , and that death occurred at <i>3:30 P.M.</i> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <i>Froyes D. Alexander M.D.</i>				23b. ADDRESS <i>826 N Channing St. Mo.</i>				23c. DATE SIGNED <i>6-28-55</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24b. DATE <i>July 2, 1955</i>		24c. NAME OF CEMETERY OR CREMATORY <i>National Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>Jefferson Barracks, Mo.</i>			
DATE REC'D BY LOCAL REG. <i>JUN 29 1955</i>		REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Wright Funeral Home 3100 Easton Ave.</i>				

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 C Claude Ho*

Licensed Embalmer No. *34*

P. O. Address *4575*

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.