

Health, Welfare Public Service

FILED OCT 3 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32158

STATE FILE NUMBER  
8087

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8087**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Lemay</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Incarnate Word</b>		d. STREET ADDRESS (If outside, give location) <b>219 W. Felton</b>	
Length of stay in lb <b>5 weeks</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>B</b> Last <b>KELLOGG</b>			4. DATE OF DEATH Month <b>8</b> Day <b>30</b> Year <b>1956</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8, 1893</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months <b>63</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Union Electric Co.</b>	11. BIRTHPLACE (City and state or country) <b>Springfield, South Dakota</b>	12. CITIZEN OF WHAT COUNTRY
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13. FATHER'S NAME <b>James Monroe Kellogg</b>	14. MOTHER'S MAIDEN NAME <b>Nellie Maud Perkins</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW-1</b>	16. SOCIAL SECURITY NO. <b>488-07-3287</b>	17. INFORMANT <b>Mrs. Dora Kellogg, 219 W. Felton ave. Lemay, Mo.</b>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia - Uremia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
DUE TO (b) <b>Toxic Nephritis - Toxic Nephritis</b>		<b>1 week</b>
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paralytic Ileus secondary to subtotal gastrectomy</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
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20c. TIME OF INJURY Hour <b>10 p.m.</b> Month, Day, Year	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20g. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from **7/23/56** to **8/30/56** and last saw him alive on **8/30/56**  
Death occurred at **10 p.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>John Summers, M.D.</b>	22b. ADDRESS <b>2264 S. Compton</b>	22c. DATE SIGNED <b>8/31/56</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Sept. 4, 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson Bks. Mo.</b>
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24. FUNERAL DIRECTOR <b>C. Hoffmeister U. &amp; L. Co.</b> ADDRESS <b>7814 S. Broadway</b>	25. DATE RECD. BY LOCAL REG. <b>SEP 1 1956</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>
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300 1-56  
All :  
No symptoms will be listed. All :  
Registrar cannot certify to a death due to natural causes.  
Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

IN FROM 2 TO 4:00 PM TODAY

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 *Linus C. Hoffmaster* .....

Licensed Embalmer No. .... 38

P. O. Address .... 78148

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (E 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.