

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 2 - 1957

42203  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District **1003** Registrar's No. **11150**

|   |                               |   |   |  |   |
|---|-------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                               |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>  |                               | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY<br>OR<br>TOWN <b>St. Louis</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                 |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <b>39 Cardinal Glennon</b>  |                               | Length of stay in lb<br><b>12 days</b>  | d. STREET<br>ADDRESS <b>23/ 1532 Mississippi</b>  |  | (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Harold</b> Middle <b>James</b> Last <b>Kelly</b>   |                               |   | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>13</b> Year <b>1957</b>  |  |   |
| 5. SEX<br><b>M.</b>   | 6. COLOR OR RACE<br><b>W.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 20, 1956</b>  | 9. AGE (In years last birthday)<br><b>1 yr. 0 23</b><br>IF UNDER 1 YEAR: Month <b>0</b> Days <b>23</b><br>IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b> |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>Fort Benning, Ga.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |
| 13. FATHER'S NAME<br><b>James Kelly</b>   |                               |   | 14. MOTHER'S MAIDEN NAME<br><b>Maria Emberger</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                               | 16. SOCIAL SECURITY NO.<br><b>none</b>  | 17. INFORMANT<br><b>James Kelly</b> Address <b>1532 Mississippi</b>   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple focal sclerosis and atrophy of the cerebral cortex.</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Spastic quadriplegia</b><br>DUE TO (c) <b>Bronchopneumonia</b> |                               |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 months</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>351x</b>  |                               |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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.)                                |  |   |
| 20c. TIME OF INJURY<br>Hour <b>12:30</b> Month <b>11</b> Day <b>13</b> Year <b>1957</b><br>a. m. p. m.  |                               |   |   |  |   |
| 20d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                               | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   | 20f. CITY, TOWN, OR LOCATION  |  | COUNTY STATE  |
| 21. I attended the deceased from <b>11/15/57</b> to <b>11/13/57</b> and last saw <sup>see</sup> him <sub>him</sub> alive on <b>11/13/57</b><br>Death occurred at <b>12:30</b> <b>11/13/57</b> m on the date stated above; and to the best of my knowledge, from the causes stated.  |                               |   |   |  |   |
| 22a. SIGNATURE<br>(Degree or title)<br><b>Edwin T. Davis M.D.</b>   |                               |   | 22b. ADDRESS<br><b>Cardinal Glennon Hospital</b>  |  | 22c. DATE SIGNED<br><b>11/15/57</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>   |                               | 23b. DATE<br><b>Nov. 14, 1957</b>   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Bonne Terre, Missouri</b>                             |
| 24. FUNERAL DIRECTOR<br><b>Caldwell</b> ADDRESS <b>Flat River, Mo.</b>  |                               | 25. DATE RECD. BY LOCAL REG.<br><b>NOV 21 1957</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>J. Carl Smith M.D.</b><br>P. M.  |   |

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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.....  
*Homer W. Jinty*

Licensed Embalmer No. 38

P. O. Address *St. Louis*

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.