

pt. Health,
, & Welfare
S. Public
alth Service

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45359
STATE FILE NUMBER

Registration District No. 282 Primary Registration District No. 3055 Registrar's No. 134

1-54

1. PLACE OF DEATH a. COUNTY Polk		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Polk	
b. CITY (If outside corporate limits, give TOWNSHIP only) Bolivar		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Bolivar Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b 5 Yrs.	d. STREET ADDRESS (If outside, give location) Box # 24 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First RALPH Middle THOMAS Last KELLY			4. DATE OF DEATH Month Dec. Day 13 Year 1957		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29 1906	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) Salesman	10b. KIND OF BUSINESS OR INDUSTRY Heating Equipment	11. BIRTHPLACE (City and state or country) Springfield, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Charles M. Kelly	13b. MOTHER'S MAIDEN NAME Elizabeth Paris	14. NAME OF HUSBAND OR WIFE Lucile Kelly
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, Yes or unknown) (If yes, give war or dates of service) Yes	16. SOCIAL SECURITY NO. 491-03-5013	17. INFORMANT Mrs. Lucile Kelly Address Bolivar, Mo.
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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) Sepsis Caused by Broncho-Pneumonia DUE TO (b) Extensive Pulmonary Emphysema DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED 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 5271	COUNTY _____ STATE _____
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21. I attended the deceased from _____ and last saw him alive on _____ Death occurred at 10:43 PM on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE W. H. Lohmeyer (Degree or title)	22b. ADDRESS Bolivar, Mo.	22c. DATE SIGNED 12-14-57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/17/57	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Springfield, Mo.
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24. FUNERAL DIRECTOR H. H. Lohmeyer ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. Dec. 18, 1957	26. REGISTRAR'S SIGNATURE Ralph Gordon per Jewell Gordon
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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DEC 31 1957

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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 *Walter E. Daniels*

Licensed Embalmer No. *3805*

P. O. Address *Springfield, Ill.*

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.