

Health, Welfare Public Service

FILED FEB 28 1958

STANDARD CERTIFICATE OF DEATH

58-007526 STATE FILE NUMBER 1785

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 1785

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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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN ST. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in lb 2 DAYS	
3. NAME OF DECEASED (Type or print) First Middle Last Jacob Henry McKelvey		4. DATE OF DEATH Month Day Year 2 12 58	
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 MAY 11, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) BUCKHORN, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME WILLIAM MCKELVEY		13b. MOTHER'S MAIDEN NAME HANNAH SOISSNER	
14. NAME OF HUSBAND OR WIFE LORA		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. UNKNOWN		17. INFORMANT Address RALPH MCKELVEY, 6940 ODELL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Cerebral arteriosclerosis DUE TO (c) 331X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH undet.
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 Death occurred at 2-10-58 6:35 P		to 2-12-58 and last saw him ^{her} alive on 2-12-58 m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Sydney J. Innes, M.D.		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 2-13-58		23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	
23b. DATE 2-18-58		23c. NAME OF CEMETERY OR CREMATORY LOCAL	
23d. LOCATION (City, town, or county) MARQUAND MO.		(State)	
24. FUNERAL DIRECTOR ADDRESS ALBERT H. Hoppe, 4700 WASHINGTON		25. DATE RECD. BY LOCAL REG. FEB 14 '58	
26. REGISTRAR'S SIGNATURE Carl Smith MD m 85.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 *John S. Kennedy*
Licensed Embalmer No. *4194*
P. O. Address *St. Louis, Mo.*

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.