

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027122

STATE FILE NUMBER 0065

FILED JUL 21 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN East St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Peoples Hosp.		d. STREET ADDRESS (If outside, give location) 321 Golden St.	

3. NAME OF DECEASED (Type or print) First Middle Last Veolor Kelly			4. DATE OF DEATH Month Day Year June 10 1958		
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5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 - 30 - 1903	9. AGE (In years last birthday) 54 yrs.	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic	10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (City and state or country) Miss.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Tom Anderson	13b. MOTHER'S MAIDEN NAME Violet Soil	14. NAME OF HUSBAND OR WIFE Sandy Kelly
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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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Sandy Kelly 321 Golden St. E. St. Louis Ill
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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) <i>Carcinoma of colon</i> <i>bowel obstruction</i> DUE TO (b) <i>3</i> DUE TO (c) <i>3</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>153.8</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3</i> <i>3</i>
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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 Month, Day, Year 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 COUNTY STATE
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21. I attended the deceased from Death occurred at <i>9 AM</i> <i>May 1-58</i> to <i>June 10-1958</i> and last saw her alive on <i>June 9-1958</i> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <i>H. G. Moore</i>	22b. ADDRESS <i>917-5018</i>	22c. DATE SIGNED <i>6-13-58</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE <i>6-16-1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Washington Park</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Co. Mo</i>
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24. FUNERAL DIRECTOR ADDRESS <i>Dunn Funeral Home 215 So. Jefferson</i>	25. DATE RECD. BY LOCAL REG. <i>JUN 13 '58</i>	26. REGISTRAR'S SIGNATURE <i>Paul Smith MD</i> <i>acm</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Arthur R. Heilliard*

Licensed Embalmer No. *4224*

P. O. Address *3100 Goston*

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.