

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041149  
STATE FILE NUMBER

FILED NOV 24 1958 Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 270

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Charles</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Ann</b> 4001 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hosp.</b>		Length of stay in lb <b>3 Days</b>	d. STREET ADDRESS (If outside, give location) <b>10909 St. Charles Rd</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>A.</b> Last <b>Kelly</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>20,</b> Year <b>1958</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>June 12 1909</b>	9. AGE (In years last birthday) <b>47</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis County 'Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Kelly</b>	13b. MOTHER'S MAIDEN NAME <b>Mollie Cochran</b>	14. NAME OF HUSBAND OR WIFE <b>Caroline Kelly</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Mollie Kelly</b> Address <b>10909 St. Charles Rd.</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>Coronary thromboses</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 hr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arteriosclerosis</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>Cirrhosis of liver</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.) <b>4201</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St. Charles, Mo</b>	COUNTY _____ STATE _____
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St. Charles, Mo</b>	COUNTY _____ STATE _____
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21. I attended the deceased from <b>June 1958</b> to <b>Nov 1958</b> and last saw <sup>him</sup> alive on <b>Nov 20, 1958</b> Death occurred at <b>1:00</b> <b>4</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Wm H Pogreben MD</b> (Degree or title)	22b. ADDRESS <b>St. Charles, Mo</b>	22c. DATE SIGNED <b>Nov 21, 1958</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/22/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
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24. FUNERAL DIRECTOR <b>Collier Mortuary, St. Ann, Mo.</b> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <b>Nov 21 - 1958</b>	26. REGISTRAR'S SIGNATURE <b>Marella Wilson</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

DEC 1 1968

DEC 1 8 1968

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 *Sheldon Collier* .....

Licensed Embalmer No. *3382* .....

P. O. Address *St. Ann* .....

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.