

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011080

STATE FILE NUMBER

2 2980

APR 6 1959 Registration District No. Primary Registration District No. Registrar No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. Louis Mo</i>		c. CITY OR TOWN <i>ST. Louis</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>FIRMIN DESLOGE HOSP.</i>		d. STREET ADDRESS (If outside, give location) <i>2929 - LEMP</i>	
Length of stay in lb <i>11 days</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>LEONARD W. KELAM</i>			4. DATE OF DEATH Month Day Year <i>MAR. 23 1959</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 19 1921</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MEAT CUTTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BETTENDORF-RAPP</i>	11. BIRTHPLACE (City and state or country) <i>Mo</i>
13a. FATHER'S NAME <i>THOMAS KELAM</i>		13b. MOTHER'S MAIDEN NAME <i>FRANCES CETINA</i>	12. CITIZEN OF WHAT COUNTRY? <i>U-S-A</i>
14. NAME OF HUSBAND OR WIFE <i>CLARA KELAM (DEC'D)</i>		17. INFORMANT Address <i>FRANCES KELAM 4104 UTAH</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>YES WAR II</i>		16. SOCIAL SECURITY NO. <i>498-10-9396</i>	
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>Pulmonary embolism</i> <i>Portal hypertension</i> <i>Cirrhosis of Liver.</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Unknown</i> DUE TO (c) <i>Unknown</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>Unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>5810</i>			19. WAS AUTOPSY PERFORMED? 1 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 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 <i>March 10, 1959</i> to <i>March 23, 1959</i> and last saw him alive on <i>March 22, 1959</i> Death occurred at <i>2 A.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Leo D. Mullen, M.D.</i>		22b. ADDRESS <i>634 N Grand St Louis</i>	22c. DATE SIGNED <i>3/24/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>MAR 25 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVE CEM.</i>	23d. LOCATION (City, town, or county) (State) <i>ST. Louis Mo</i>
24. FUNERAL DIRECTOR <i>Thomas Katie 2906 Gravier</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 24 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

684 N. Front
Rt 1-3110

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 Samuel Hill

Licensed Embalmer No. 4342

P. O. Address 2906 Prairie

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.