

STANDARD CERTIFICATE OF DEATH

59-019322
STATE FILING NUMBER
24819

FILED JUN 1 1959

Registration District No. Primary Registration District No. Registration No.

1. PLACE OF DEATH a. COUNTY - - -		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5622 Delmar		Length of stay in Ib... Many Yrs	d. STREET ADDRESS (If outside, give location) 5622 Delmar Blvd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last William J. Kiely			4. DATE OF DEATH Month Day Year 5 16 1959
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 Oct. 17, 1871
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Theatrical		10b. KIND OF BUSINESS OR INDUSTRY Stage	11. BIRTHPLACE (City and state or country) St. Louis Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Kiely	
13b. MOTHER'S MAIDEN NAME Julia Kennedy		14. NAME OF HUSBAND OR WIFE Margaret Kiely	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs Julia Kiburz 7051 Perding Ave
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senile arterio sclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Senility DUE TO (c) 450.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 15 yrs.
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 Feb 19 59, to May 16 59 and last saw her alive on May 15 59 Death occurred at 10.30 AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. J. Kessler, M.D.		22b. ADDRESS 3504 7th	22c. DATE SIGNED 5-16-59
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE May 19, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR ADDRESS Arthur J. Donnelly 3840 Lindell Blvd		25. DATE RECD. BY LOCAL REG. MAY 18 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1:30 to 4:00

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 *Francis Williams*

Licensed Embalmer No. *3565*

P. O. Address *3840 Linden*

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.