

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS MAR 25 1960**

**60-012813**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2-3006**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>52-yrs.</b>	c. CITY OR TOWN <b>St. Louis</b>		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. John's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4404 Lindell Blvd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>F.</b> Last <b>Kelly</b>			4. DATE OF DEATH Month <b>March</b> Day <b>12th.</b> Year <b>1960</b>		
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</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>6/7/1875</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Pres. U.F. Kelly</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ink Co.</b>	11. BIRTHPLACE (City and state or country) <b>Acton Ontario, Canada</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
13a. FATHER'S NAME <b>Patrick Kelly</b>		13b. MOTHER'S MAIDEN NAME <b>Julia Ahern</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Gertrude Kelly</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown)   (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>492-09-7431</b>		17. INFORMANT Address <b>Mrs. Gertrude Kelly, 4404 Lindell Blvd.</b>	

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>Carcinoma of the colon with metastasis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 year.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (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)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____					
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	
21. I attended the deceased from <b>3-11-59</b> to <b>3-12-60</b> and last saw <sup>her</sup> him alive on <b>3-12-60</b> Death occurred at <b>11:15 pm.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Charles R Doyle MD</b>			22b. ADDRESS <b>634 N. Grand Blvd.</b>		22c. DATE SIGNED <b>3-14-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Mar. 16, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR <b>Walter J. Dornell</b> ADDRESS <b>3840 Lindell Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 15 1960</b>		26. REGISTRAR'S SIGNATURE <b>Neal Smith M.D.</b> <b>M. J. B.</b>	

DOCUMENT

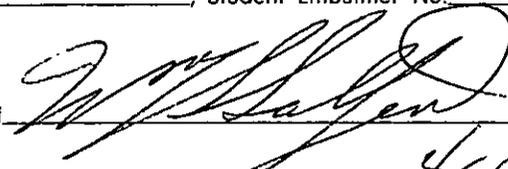
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 4699

P. O. Address 3840 Lend

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.