URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUL 18 1960

NDED

60-028509

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5917 STATE FILE NUMBER

DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 6 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Cardinal Glennon Hosp
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Rock Hill 4631
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 9219 Crawford Ave.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Middle Last: MICHAEL FRANCIS KELLY

4. DATE OF DEATH Month Day Year: June 8, 1960

5. SEX: male
6. COLOR OR RACE: white
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: June 2, 1960
9. AGE (last birthday): IF UNDER 1 YEAR Months: Days: 6 IF UNDER 24 HR Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: John Kelly
13b. MOTHER'S MAIDEN NAME: Pauline Ann Coleman
14. NAME OF HUSBAND OR WIFE: --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: John Kelly, 9219 Crawford Ave. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Hydronephrosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 7573
INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 6-2-60, to 6-8-60 and last saw her/him alive on 6-8-60
Death occurred at 12 Noon 6-8-60 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): James R Donahoe MD
22b. ADDRESS: 950 Francis Place
22c. DATE SIGNED: 6-8-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: June 10, 1960
23c. NAME OF CEMETERY OR CREMATORY: St. Peter's Cem.
23d. LOCATION (City, town, or county) (State): Kirkwood, Mo.

24. FUNERAL DIRECTOR ADDRESS: M.J. Croghan, 831 East Big Bend Webster Groves 19, Mo.
25. DATE RECD. BY LOCAL REG.: JUN 9 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

**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.

Not Embalmed

Student _____ Signed _____

Signature of Student Embalmer

M J Cogan

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.