

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045723

FILED VS DEC 27 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1246A STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE _____ b. COUNTY <u>0396</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield, Missouri</u>		Length of stay in lb <u>2yrs. 135dys</u>	c. CITY OR TOWN <u>Transient</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Medical Center For Federal Prisoners</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>(nm)</u> Last <u>Kelly</u>			4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-1914</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Professional Hobo</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hobo</u>		11. BIRTHPLACE (City and state or country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Michael Kelly</u>		13b. MOTHER'S MAIDEN NAME <u>Lissie (unknown) Kelly</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes 1917-1920</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>MCFP Files, Springfield, Missouri</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>left cerebral encephalomalacia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>	
DUE TO (b) <u>cerebral thrombosis</u>			<u>4 weeks</u>
DUE TO (c) <u>cerebral arteriosclerosis</u>			<u>years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic heart disease</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? 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 _____ 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 August 1, 1958 to December 14, 1960 last saw her/him alive on December 14, 1960
Death occurred at 3:40 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Clarence Kooiker, M.D.</u> (Degree or title) <u>Director</u>		22b. ADDRESS <u>MCFP Springfield, Missouri</u>		22c. DATE SIGNED <u>12-16-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12/19/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEMETERY</u>	23d. LOCATION (City, town, or county) <u>SPRINGFIELD, MO.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>H.H. LOHMEYER FUNERAL HOME</u> <u>SPRINGFIELD, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>12-19-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>		

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 Frederic M. Abbott

Licensed Embalmer No. 5115

P.O. Address Springfield

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.