MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6720 STATE FILE NUMBER 61-026991

FILED AUG 3 1961

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5589 A. Wells Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Harold Middle Cecil Last Kelley
4. DATE OF DEATH: Month 7 Day 16 Year 61
5. SEX: Male
6. COLOR OR RACE: Col
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8/16/29
9. AGE (last birthday): 31
IF UNDER 1 YEAR: Months 11 Days 0
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Winn, Ark
12. CITIZEN OF WHAT COUNTRY: USA.
13a. FATHER'S NAME: Howard Kelley
13b. MOTHER'S MAIDEN NAME: Mary Thomas
14. NAME OF HUSBAND OR WIFE: Donie Kelley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): W.W. #2 (If yes, give war or dates of service): W.W.#2
16. SOCIAL SECURITY NO.
17. INFORMANT: Donie Kelley Address: 5943 Theodosia

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): Coronary Occlusion (Sclerosis).
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 4201
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 ____ to ____ and last saw her/him alive on ____
Death occurred at 12:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Paul J. Simon (Degree or title): Deputy Coroner
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 7/19/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 7/21/61
23c. NAME OF CEMETERY OR CREMATORY: Washington Park Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: Wright Funeral Home
ADDRESS: 3100 Easton Ave.
25. DATE RECD. BY LOCAL REG.: JUL 19 1961
26. REGISTRAR'S SIGNATURE: Neal Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
6			

BY AFFIDAVIT OF DOCUMENT

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 Arthur L. Houlihan

Licensed Embalmer No. 4221

P. O. Address 3100 Easton Ave

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.