

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031342

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2272

AMENDED

FILED AUG 28 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rock Hill</u>		Length of stay in lb <u>1 yr.</u>	c. CITY OR TOWN <u>Maplewood</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rock Hill Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2601 Circle Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Kellogg</u> Last <u>Kellogg</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>10th</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-1889</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11. BIRTHPLACE (City and state or country) <u>Spencer Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret Kellogg</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Margaret Kellogg</u> Address <u>Above</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>Bronchial Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
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) <u>Generalized Arteriosclerosis</u>		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	
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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
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21. I attended the deceased from July 14, 1961 to Aug 10, 1961 and last saw ^{her} him alive on Aug 10, 1961
Death occurred at 7 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert D Sanders MD</u>	(Degree or title)	22b. ADDRESS <u>1502 Care Dr. St Louis</u>	22c. DATE SIGNED <u>8-12-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	23b. DATE <u>8-14-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Mausoleum</u>	23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u>	(State)
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24. FUNERAL DIRECTOR <u>JAY B. SMITH, Maplewood, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-11-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Muffly M.D.</u>
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

JUL 19 1962

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 Melvin Bartens

Licensed Embalmer No. 4903

P. O. Address St. Louis

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.