

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-006805

STATE FILE NUMBER

AMENDED

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 96

FILED FEB 27 1962

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY COOK		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN INDEPENDENCE		Length of stay in 1b Transit		c. CITY OR TOWN CHICAGO Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 10227 E. 40 Hiway			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4000 E. 112th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First THOMAS Middle KELLY Last			4. DATE OF DEATH Month FEBRUARY Day 22 Year 1962		
5. SEX MALE	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-8-1911	9. AGE (last birthday) 50	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) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR	11. BIRTHPLACE (City and state or country) CHICAGO, ILLINOIS		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME THOMAS KELLY		13b. MOTHER'S MAIDEN NAME ANNIE MC AVOY		14. NAME OF HUSBAND OR WIFE DOROTHY KELLY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO WWII		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address Thomas Kelly, Sr., Chicago, Illinois		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest Fractured Legs DUE TO (b) Numerous Contusions DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					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) Autopsy & Inspection				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 checked="" 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.) No car collision			
20c. TIME OF INJURY Hour 3:15 a.m. Month, Day, Year 2-22-62	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway	20f. CITY, TOWN, OR LOCATION Independence	COUNTY Jackson	STATE MO
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Kath H Owens Coroner			22b. ADDRESS 152 mmn Station		22c. DATE SIGNED 2-22-62
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 2-22-62	23c. NAME OF CEMETERY OR CREMATORY MT. - CAMEL - CEMETERY		23d. LOCATION (City, town, or county) (State) HILLSIDE, ILLINOIS	
24. FUNERAL DIRECTOR GEO. C. CARSON & SONS, INDEPENDENCE, MO.		ADDRESS	25. DATE RECD. BY LOCAL REG. 2-22-62	26. REGISTRAR'S SIGNATURE Alba L. Craig	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

MAR 1 1962

MAR 29 1962

MAY 16 1963

JUL 19 1962

MAR 13 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

Leroy J. Tyler

Licensed Embalmer No. 4941

P. O. Address Independence

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.