

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020597

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District **1003** Registrar's No. **5241**

FILED MAY 31 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 3 yrs. 10 mo.	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Mo. b. COUNTY St. Louis		c. CITY OR TOWN Baldwin St. Louis		Inside limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Box 76, Baldwin, Mo.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Josephine Middle Kelley Last Kelley			4. DATE OF DEATH Month 5 Day 22 Year 62			5. SEX Female		6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-25-73	9. AGE (last birthday) 89	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HR Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk.			10b. KIND OF BUSINESS OR INDUSTRY unk.			11. BIRTHPLACE (City and state or country) Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.					
13a. FATHER'S NAME unk.				13b. MOTHER'S MAIDEN NAME unk.				14. NAME OF HUSBAND OR WIFE George Kelley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unk.				16. SOCIAL SECURITY NO. unk.		17. INFORMANT St. Vincent de Paul 4140 Rendell							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia											INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											DUE TO (b) 491X		
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Syphilitic heart disease										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			
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 7-7-58 to 5-22-62 and last saw her/him alive on 5-22-62 Death occurred at 12:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE J. Smith M.D. (Degree or title)						22b. ADDRESS			22c. DATE SIGNED 5/23/62 (State)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)						
Burial		5/24/62		Calvary Cemetery			St. Louis Mo						
24. FUNERAL DIRECTOR Curly Kelly 7267 Natural Bridge ADDRESS				25. DATE RECD. BY LOCAL REG. MAY 24 1962		26. REGISTRAR'S SIGNATURE Head Smith, M.D.							

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.

Not Embalmed

Student _____

Signature of Student Embalmer

Signed: *James A. Summers*

Licensed Embalmer No. 4142

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.