

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-025506

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 545 Registrar's No. 1802 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 6 1962

VS 300  
Rev. 4/59

4604

2 204

3

4 1

5 0

6

7 0

8 2

94200

10

11

12 860

13

88

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Maplewood</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>2 Yr. 3 Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Maplewood Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>2200 Richert Ave.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Laura Agnes Kelley</b>			4. DATE OF DEATH Month Day Year <b>June 16 1962</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-23-1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) <b>Trained Nurse (Ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>
13a. FATHER'S NAME <b>George D.L. Kelley</b>		13b. MOTHER'S MAIDEN NAME <b>Jessie Ure Kelley</b>	
14. NAME OF HUSBAND OR WIFE <b>- - -</b>		17. INFORMANT Address <b>Webster Groves, 19</b> <b>Mr. George Kelley, 48 Sylvester,</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes. 1 W.W. 1</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
DUE TO (b) <b>Generalized Arteriosclerosis</b>			<b>3 years</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)			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 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	
21. I attended the deceased from <b>Jan 1951</b> to <b>June 16, 1962</b> and last saw her/him alive on <b>June 15, 1962</b> Death occurred at <b>12:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>James B. Jones, M.D.</b>		22b. ADDRESS <b>9313 Manchester Road St. Louis 19 Mo.</b>	
22c. DATE SIGNED <b>6-16-62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>6-18-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo</b>
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons, 6175 Delmar Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>6-18-62</b>	
		26. REGISTRAR'S SIGNATURE <b>John C. Murphy, M.D.</b>	

Dr. J.B. Jones  
9313 Manchester

WO 1-5656

(In office 3:00 to 3:30 P.M. Sat.)

**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

*Geo. E. McCulloch*

Licensed Embalmer No. 2468

P. O. Address 6175 Pelmar

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.

4-1-1958