

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013471

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2818**

STATE FILE NUMBER

FILED MAR 20 1963

DO NOT WRITE ON THIS STUD

AMENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,		Length of stay in 1b 2 Mos	c. CITY OR TOWN 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 5500 South Broadway Edgewater Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4535 Lindell Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Bridget O'Malley KIELY			4. DATE OF DEATH Month Day Year March 9, 1963
5. SEX Female	6. COLOR OR RACE Caucasian	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-23-75
9. AGE (last birthday) 87		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Scranton, Pa.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME John C. O'Malley	
13b. MOTHER'S MAIDEN NAME Elizabeth Dacey		14. NAME OF HUSBAND OR WIFE John T. Kiely (Dec)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT John C. Kiely, 5819 Delor		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 450.0			DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic 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 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 Month, Day, Year s.m. p.m.	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 Jan 17, 1963 to March 9, 1963 and last saw her ^{her} alive on March 9, 1963 Death occurred at 5:40 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert J. Sanders, MD		22b. ADDRESS 5500 S Broadway	22c. DATE SIGNED 9-11-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-13-63	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Robert J. Sanders		ADDRESS 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. MAR 11 1963
		26. REGISTRAR'S SIGNATURE Coal Smith, M.D.	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF DOCUMENT

MEDICAL CERTIFICATION

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

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DR. ROBERT SANDERS
5500 S. BROAD
AUSTIN 1:00 PM

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 *Robert Sanders*

Licensed Embalmer No. 4699

P. O. Address 3840 Lindell

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.