S. No. 2
0M—2-43
v. 5-17-39
I X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 28 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21314

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6308

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Anthony's Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 1/2 days (Specify whether years, months or days)
In this community 21 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 3861 A. Sha w Ave. (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Kelly Daniels

3. (b) If veteran, name war no

3. (c) Social Security No. 489-10-1743

4. Sex M.

5. Color or race W.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Hazel

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased September (Month) 1 (Day) 1904 (Year)

8. AGE: Years 40 Months 10 Days 18 If less than one day hr. min.

9. Birthplace Wa yne County (City, town, or county) Ill. (State or foreign country)

10. Usual occupation Chauffer

11. Industry or business Be Mac Trucking Co.

FATHER
12. Name William Daniels
13. Birthplace Jefferson County Ill. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lucindia Glaspay
15. Birthplace Wayne County (City, town, or county) Ill. (State or foreign country)

16. (a) Informant H azel Daniels

(b) Address 3861 A. Shaw

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/45 (Month) (Day) (Year)

(c) Place: burial or cremation New S t . Marcus

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette

19. (a) (Date received local registrar) JUL 2 1 1945 (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19 year 1945 hour 3 minute 00 A. M.

21. I hereby certify that I attended the deceased from July 18, 1945, to July 18, 1945; that I last saw h alive on July 18, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured duodenal ulcer

Due to Peritonitis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature H. S. Pope (M. D. or other) M. D.

Address 1803 Pendleton Date signed 7-21-45

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed. L. R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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 this body is not embalmed, fact should be so stated above.