

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County *St. Louis*  
Township *St. Ferdinand* Registration District No. *784* File No. *65957*  
or  
Village ..... Primary Registration District No. *6030* Registered No. *13*  
or  
City *Florissant* (NO. ....) St. .... Ward) III death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*John Lambert Keeran*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *single*  
6 DATE OF BIRTH *Jan. 24 1915*  
(Month) (Day) (Year)  
7 AGE *13* yrs. mos. ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *none*  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) *Florissant Mo*

PARENTS  
10 NAME OF FATHER *Serman Keeran*  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Missouri*  
12 MAIDEN NAME OF MOTHER *Helmina Drake*  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Missouri*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Serman Keeran*  
(Address) *Florissant Mo.*

15 Filed *July 6* 1915 *J. J. Douglas* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Feb. 5* 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Feb. 3* 1915 to *Feb. 5* 1915, that I last saw him alive on *Feb. 5* 1915, and that death occurred, on the date stated above, at *12 P.M.*

The CAUSE OF DEATH\* was as follows:  
*Meningitis*  
*18*  
(Duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) (Duration) ..... yrs. .... mos. .... ds.

(Signed) *J. J. Williamson* M. D.  
*Feb. 6* 1915 (Address) *Florissant Mo.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.  
Where was disease contracted if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL *Sacred Heart Florissant* DATE OF BURIAL *2/7/15*

20 UNDERTAKER *J. Rock* ADDRESS *1650 Gaston Av.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

## PLACE OF DEATH

County

St. Louis  
Mo.

Township

or

Village

or

City

REGISTRARS SHALL NOT RE-  
CEIVE A FEE FOR CERTIFICATED  
UNTIL THEY ARE COMPLETED AS  
PRESCRIBED BY LAW.

## MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

Registration District No.

784

File No.

Primary Registration District No.

6030

Registered No.

13

No.

St.

Ward

(If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number)

## FULL NAME

John Lambert Keenan

## PERSONAL AND STATISTICAL PARTICULARS

SEX

M

COLOR OR RACE

W

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

S

DATE OF DEATH

(Month)

(Day)

1915

DATE OF BIRTH

(Month)

(Day)

(Year)

AGE

yrs. mos. ds.

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

## BIRTHPLACE

(City or town,  
State or foreign country)

PARENTS

NAME OF  
FATHERBIRTHPLACE  
OF FATHER  
(City or town, State or foreign country)MAIDEN NAME  
OF MOTHERBIRTHPLACE  
OF MOTHER  
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

716 1915 J. V. Douglas

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

I HEREBY CERTIFY, that I attended deceased from  
, 191, (to), 191,  
that I last saw him alive on, 191,  
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Meningitis  
Epidemic  
(Duration) yrs. mos. ds.

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

J. J. Williamson M. D.  
1605 (Address) Gloucest. Mo.\*State the Disease Causing Death, or, in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR  
RECENT RESIDENTS)At place  
of death, yrs. mos. ds. In the  
State yrs. mos. ds.Where was disease contracted  
if not at place of death?Former or  
usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

UNDERTAKER

John Koch &amp; Son

ADDRESS

Waco Center

Original file, date

Apr 15 1915

Information called for must be written on this Supplementary Certificate.

ACTUALLY. PHYSICIANS should state  
out of OCCUPATION is very important.  
Information should be carefully supplied. AGE should be  
given in plain terms, so that it may be properly classified. Exag-

SUPPLEMENTARY

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