

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

Do not use this space.

25621

1. PLACE OF DEATH

County St. Louis
Township St. Louis
City St. Louis

Registration District No. 791
Primary, Registration District No. 10037

File No. _____
Registered No. 7218
St. _____ Ward _____

2. FULL NAME

James (Keane) Keane
(a) Residence No. Wenderson 23 Ward. _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Wenderson

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs or _____ min
About 35

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Ireland
(STATE OR COUNTRY)

10. NAME OF FATHER Hugh Keane

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Edith Keane

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY)

14. INFORMANT Peter Keane
(Address) 1412 Marvill

15. AUG -9 1927
FILED _____ 19 _____ male Starbuck
REGISTRY

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 8 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at na

THE CAUSE OF DEATH* W S AS FOLLOWS:

1930 Myocardial
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) WMA
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH: _____

8 DID AN OPERATION PRECEDE DEATH. DATE OF _____
WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) A. J. Davis, M. D.
, 19____ (Address) Carroll

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary DATE OF BURIAL 8/11 1927

20. UNDERTAKER Cullen Kelly ADDRESS 4524 Easton

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.

THIS IS A PERMANENT RECORD

