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

Do not use this space.

34861

File No. .....

Registered No. 10003

1. PLACE OF DEATH

County .....

Registration District No. 791

Township .....

Primary Registration District No. 1003

City St. Louis (No. 1102 Market St. St. ..... Ward)

2. FULL NAME William Keane.

(a) Residence. No. 1102 Market St., St., 25 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
Alt 42	✓	✓	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) ?
(STATE OR COUNTRY) Mass.

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER ✓

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

14. INFORMANT Wm Dever
(Address) Coroner Office

15. NOV -9 1927 Mary E. Hilscoff
FILED ..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-7 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 1:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) W. M. A.
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
11/8, 1927 (Signed) Wm Dever, M. D.
(Address) Dep Coroner

*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 Kansas City. Mo — DATE OF BURIAL 11-10 1927

20. UNDERTAKER Southern — ADDRESS 7316 S B'dway

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.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD