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

Do not use this space.

12483

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 3006

City St Louis Mo, (No. 4317 Forest Park Blvd St. ..... Ward)

2. FULL NAME Montrose Keithcart

(a) Residence. No. 4317 Forest Park Blvd St., 19 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	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 16.1924

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	4	7	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Chicago
(STATE OR COUNTRY) Ill.s

PARENTS

10. NAME OF FATHER Ray Keithcart

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

12. MAIDEN NAME OF MOTHER Marguerite Shriner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo

14. INFORMANT Mrs Marguerite Keithcart
(Address) 4054 Lincoln Ave

15. FILED MAR -9 1929 19 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

Lowell Dead

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 8 1929

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 11 50 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Asphyxiation due to fuel Gas Poisoning administered by Father,
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Homicide,
..... (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? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. B. Hurley M.D.
3/9, 1929 (Address) Deputy 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 Calvary Cemetery DATE OF BURIAL 3/11 1927

20. UNDERTAKER Geo E. Mahler ADDRESS 4725 St Louis Ave

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

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.