

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.

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

Do not use this space.

NOV 13 1934

35243

1. PLACE OF DEATH

County Buchanan Registration District No. ....  
Township ..... Primary Registration District No. ....  
City St. Joseph (No. 2739 Penn street) St. .... Ward)

File No. ....  
Registered No. 1126

2. FULL NAME Charles S. Keane

(a) Residence, No. 2739 Penn street St. .... Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Married</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Margaret B. Keane</b>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>November 17, 1873</b>		
7. AGE	YEARS	MONTHS
	<b>60</b>	<b>10</b>
		<b>16</b>
	If LESS than 1 day, ..... hrs. or ..... min.	

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <b>Liquidator Wheeler</b>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <b>Dry Goods Co.</b>
	10. Date deceased last worked at this occupation (month and year) <b>1934</b>
	11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) **Columbus** (STATE OR COUNTRY) **Ohio**

FATHER 13. NAME **Patrick Keane**

FATHER 14. BIRTHPLACE (CITY OR TOWN) **Unknown** (STATE OR COUNTRY) **Ireland**

MOTHER 15. MAIDEN NAME **Ellen Kelly**

MOTHER 16. BIRTHPLACE (CITY OR TOWN) **Unknown** (STATE OR COUNTRY) **Ireland**

17. INFORMANT **Mrs Margaret Keane** (ADDRESS) **2739 Penn st St Joseph Mo.**

18. BURIAL, CREMATION, OR REMOVAL **Mt Olivet Cemetery** PLACE **St Joseph Mo.** DATE **Oct. 5** 19 **34**

19. UNDERTAKER **H. O. Sidenfaden** (ADDRESS) **St Joseph Mo.**

20. FILED **10-4** 19 **34** **John R. Bender** Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **October 3** 19 **34**

22. I HEREBY CERTIFY, That I attended deceased from **Nov 6** 19 **34** to **Nov 5** 19 **34**

I last saw him alive on **Nov 1** 19 **34**. Death is said

to have occurred on the date stated above, at **7:40 A.** m.

The principal cause of death and related causes of importance were as follows:

**Sept Rheumatism, Chronic Endocarditis**

Other contributory causes of importance:

**92, 95C, 95A**

Name of operation ..... Date of ..... **7/11**

What test confirmed diagnosis **clinical** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19 .....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? **No**

If so, specify .....

(Signed) **John R. Bender**, M. D.

(Address) **St Joseph Mo**

