

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.

AUG 9 1935

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

Do not use this space.

24843

1. PLACE OF DEATH

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

Registration District No. **791**  
**1003**  
Primary Registration District No. *St. Louis*  
(No. *3874*)

File No. **6276**  
Registered No. **6276**  
St. .... Ward)

2. FULL NAME

*Rose Keating*  
(a) Residence, No. *3735 Minnesota St.* *16* 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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>April 19-1873</i>		
7. AGE	YEARS <i>62</i>	MONTHS <i>3</i>
	DAYS <i>1</i>	If LESS than 1 day, .....hrs. or .....min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>hwb.</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year).....	11. Total time (years) spent in this occupation.....
MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Scranton Pa.</i>	
	13. NAME <i>Austin Keating</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ireland</i>	
	15. MAIDEN NAME <i>Ann Mc Mann</i>	
FATHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ireland</i>	
	17. INFORMANT <i>John Keating</i>	
	(ADDRESS) <i>3735 Minnesota</i>	
	18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Calvary</i> DATE <i>7-24-35</i>	
OSCAR V. HOFFMEISTER UND.		
19. UNDERTAKER (ADDRESS) <i>4016-18 CHIPPEWA ST.</i>		
20. FILED <i>JUL 23 1935</i> <i>J. Bredeck</i> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7-20-35*, 19

22. I HEREBY CERTIFY, That I attended deceased from *7/12*, 19, to *7/20/35*, 19, I last saw h. *alive on 7/20/35*, 1935. Death is said to have occurred on the date stated above, at *9:30 p.m.*

The principal cause of death and related causes of importance were as follows:  
*Uraemia Cause unknown*

Date of onset *7/12*

Other contributory causes of importance:  
*Nephritis Acute - caused by uremia*

130

Name of operation..... Date of.....  
What test confirmed diagnosis? *Uremia* 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) *W. Simpson*, M. D.  
(Address) *3729 9th av.*

