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

DEC'D MAR 13 1939

5210
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. .....
(b) Township ..... Primary Registration District No. ..... Registered No. 1903
(c) City St. Louis, Missouri (d) Street No. City Sanitarium St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 75 yrs. 1 mos. 24 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sophia Keogh
(a) Residence, No. 1844 Division St St. 21
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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: Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 1-3-1864
7. AGE: 75 YEARS: 75 MONTHS: 1 DAYS: 24 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Cook
9. Industry or business in which work was done, as saw mill, bank, etc.: Unknown
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St. Louis, Missouri 0

FATHER
13. NAME: Wm. Keogh 5
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown Ireland 5

MOTHER
15. MAIDEN NAME: Sophia McCafferty
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown Ireland

17. INFORMANT (ADDRESS): Henry C. Gehrand, M.D. 5400 Arsenal St
18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary DATE Feb. 28, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Bromschwig Funeral Home 4746 W. Florrisant
20. FILED FEB 28 1939 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 2-27-39, 19

22. I HEREBY CERTIFY, That I attended deceased from 7-1-38, 19..., to 2-27-39, 19...
I last saw her alive on 2-27-39, 19... Death is said to have occurred on the date stated above, at 5:00 A.M.
The principal cause of death and related causes of importance were as follows:

Chronia Nephritis 1-21-39x Date of onset

131

Other contributory causes of importance: (non catarrhal, non tubercular, non pyococcus)
Cystitis 1-21-39x
Chronic Myocarditis

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? Yes

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? .....
If so, specify .....
(Signed) Henry C. Gehrand, M. D.
(Address) 5300 Arsenal

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Guy W Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.