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.

REC'D JUN 1 1939

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

16910
Do not use this space.

791
1003

1. PLACE OF DEATH
(a) County ..... Registration District No. .....
(b) Township ..... Primary Registration District No. ..... Registered No. 4444
(c) City St. Louis (d) Street No. Jewish Hospital 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 500 Mary A. Keehne,
(a) Residence, No. 3401 Sublette. St. 14
(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): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Charles F. Keehne

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): March 6 1852

7. AGE: YEARS 87 | MONTHS 2 | DAYS 6 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Housework
9. Industry or business in which work was done, as saw mill, bank, etc.
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): Maryland

FATHER
13. NAME: Thomas Kearey
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Virginia

MOTHER
15. MAIDEN NAME: Mary Kaylor
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Virginia

17. INFORMANT (ADDRESS): Mrs. Sadie Humes 3401 Sublette,

18. BURIAL, CREMATION, OR REMOVAL
PLACE New St. Marcus DATE 5-15-39, 19

19. FUNERAL DIRECTOR (ADDRESS): Louis H Bopp Kirkwood, Mo.,

20. FILED MAY 14 1939 19 J. F. Bucheck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-12-39, 19

22. I HEREBY CERTIFY, That I attended deceased from Feb 15, 1939, to May 12, 1939
I last saw her alive on May 11, 1939. Death is said to have occurred on the date stated above, at 9 45/4 m.
The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage — Date of onset 2-15-39

Other contributory causes of importance:
Hypertension

Name of operation None Date of
What test confirmed diagnosis? — 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) Bert Klein, M. D.
(Address) 2637 S Kingshighway

(Licensed Embalmer's Statement on Reverse Side)

I X12004

4444

4444

STATEMENT BY LICENSED EMBALMER

I, John M Meyer, Licensed Embalmer No. 3388

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed John M Meyer

Licensed Embalmer No. 3388

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