DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JUL 12 1939

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 20630

Registration District No. 1008 | Primary Registration District No. | Registrar's No. 5474

**1. PLACE OF DEATH:**

(a) County: City Hospital No. 1

(b) City or town: St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)
In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: ~~St. Louis~~

(c) City or town: St. Louis, Missouri 14
(If outside city or town limits, write "RURAL")

(d) Street No.: 6438 Lindenwood
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years

3. (a) PRINT FULL NAME: John Keaton

3. (b) If veteran, name war: —

3. (c) Social Security No.: 494-05-2304

4. Sex: male

5. Color or race: white

6. (a) Single, widowed, married, divorced: single

6. (b) Name of husband or wife: —

6. (c) Age of husband or wife if alive: — years

7. Birth date of deceased: Jan 21, 1876 (Month) (Day) (Year)

8. AGE: Years 63 | Months 4 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace: Missouri (City, town, or county) (State or foreign country)

10. Usual occupation: nil

11. Industry or business: 0

MOTHER FATHER

12. Name: Lennox Keaton

13. Birthplace: Missouri (City, town, or county) (State or foreign country)

14. Maiden name: Emaline Farmer

15. Birthplace: Missouri (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: M. Kent

(b) Address: City Hospital No. 1

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: JUNE 20-39 (Month) (Day) (Year)

(c) Place: burial or cremation: DIXON MO.

18. (a) Signature of funeral director: E. J. Lehmer

(b) Address: 3125 Lafayette Av.

19. (a) JUN 20 1939 (Date received by local registrar) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 19, 1939 year ____ hour 12.45 minute 9 M.

21. I hereby certify that I attended the deceased from 6/12/39 to 6/19/39, 19__, to ____, 19__; that I last saw him alive on 6/19/39, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Cardio-Vascular Disease

Duration

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations:

Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: William Sapsin (M. D. or other)

Address: City Hospital No. 1 Date signed:

(Licensed Embalmer's Statement on Reverse Side)

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.

USE STANDARD BLACK INK MAKES A PERMANENT RECORD

X19311

## 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 Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette Ave

**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.)**

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