No. 2
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X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23148

REGISTERED AUG 28 1941

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 5500

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Little Sisters of the Poor
2209 Hebert Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Two Years (Specify whether years, months or days)
In this community About 60 years /

2. USUAL RESIDENCE OF DECEASED:

000
17
20 9

(a) State Missouri (b) County

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

(d) Street No. 4200 W. Kossuth
(If rural, give location)

0

(e) If foreign born, how long in U. S. A.? about 60 yrs years.

3. (a) PRINT FULL NAME James Keefe

3. (b) If veteran, name none

3. (c) Social Security No. none

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Addie Moore

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

7. Birth date of deceased Dont Know (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
about 63			hr. min.

9. Birthplace County Mayo (City, town, or county) Ireland 4 (State or foreign country)

10. Usual occupation Route Boss (Retired0 /

11. Industry or business Dairy

MOTHER FATHER

12. Name James Keefe /

13. Birthplace County Mayo (City, town, or county) Ireland 4 (State or foreign country)

14. Maiden name Cecelia Whalen

15. Birthplace (City, town, or county) Ireland 4 (State or foreign country)

16. (a) Informant Michael Keefe

(b) Address 4200 W. Kossuth

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5, 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Thos J Finnan

(b) Address 1519 South Grand Blvd

19. (a) JUL 3 1941 (Date received local registrar) (b) J. H. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2, year 1941 hour 11:15 minute a. M.

21. I hereby certify that I attended the deceased from June 18, 1941, to July 2, 1941 that I last saw h. alive on July 2, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis — Duration 2 weeks

Due to

Due to

Other conditions Arteriosclerosis; Paralysis Agitans
(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?

While at work? (Specify type of place) (e) Means of injury

23. Signature Anthony A. Chefovaki (M. D. or other) M.D.

Address 1525 Gravois Ave Date signed 7/3/41

(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.....

Licensed Embalmer No. 1197

P. O. Address.....

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

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