

S. No. 2
M-9-4-41
v. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28880

State File No. _____
Registrar's No. 7804

REG OCT 6 1942

Registration District No. _____ Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. 3 days
(Specify whether _____)
In this community 14 years
years, months or days

3. (a) PRINT FULL NAME Calvin Keys
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 15th 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 2 8 _____ hr. _____ min.

9. Birthplace Miss. _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business Nil

MOTHER FATHER
12. Name Horace Keys
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Mandy Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Shirley M. Smith
(b) Address 2601 N. Whittier

17. (a) Burial (b) Date thereof SEP 24 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY
18. (a) Signature of funeral director Geo Hamilton
(b) Address City Health Dept

19. (a) SEP 23 1942 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis, 17
(If outside city or town limits, write "RURAL") 9.25
(d) Street No. 1443 N. 10th St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23,
year 1942 hour 11 minute 00 A. M.
21. I hereby certify that I attended the deceased from July 20,
1942 19 to August 23, 19 42
that I last saw h. in alive on August 23, 19 42
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertrophied Prostate Duration Unk.
Due to _____
Due to 1/27
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____ PHYSICIAN _____
Of operations _____ Underline the cause to which death should be charged statistically.
Of autopsy _____

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 0
23. Signature A. H. Keys (M. D. or other) _____
Address 2601 N. Whittier Date signed 9/25/42

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.....

P. O. Address.....

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, fact should be so stated above.