S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 12351

FILED APR 23 1943

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3516

1. PLACE OF DEATH:

(a) County: ST LOUIS

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

(c) Name of hospital or institution: BARNES HOSPITAL

(If not in hospital or institution, write street number or location)

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

In this community:

2. USUAL RESIDENCE OF DECEASED:

(a) State: OREGON (b) County: JACKSON 997

(c) City or town: ASHLAND 35 (If outside city or town limits, write "RURAL")

(d) Street No.: N.R. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country: 9

3. (a) PRINT FULL NAME: IVAN FLOYD KEENEY

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: M

5. Color or race: W

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

6. (b) Name of husband or wife:

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

7. Birth date of deceased: Jan (Month) 21 (Day) 1916 (Year)

8. AGE: Years 27 Months 2 Days ~~16~~ 22 If less than one day hr. min.

9. Birthplace: MALHEUR COUNTY (City, town, or county) OREGON (State or foreign country)

10. Usual occupation: MEDICAL STUDENT

11. Industry or business: ~~JOHN F. KEENEY~~

MOTHER FATHER

12. Name: JOHN F. KEENEY ~~OREGON~~

13. Birthplace: ~~ETH~~ (City, town, or county) OREGON (State or foreign country)

14. Maiden name: ETHEL KLINEFELTER

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

16. (a) Informant: MRS ETHEL KEENEY

(b) Address: ASHLAND OREGON

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof: 4-13-43 (Month) (Day) (Year)

(c) Place: burial or cremation: ASHLAND, OREGON

18. (a) Signature of funeral director: ALBERT H HOPPE

(b) Address: 4700 WASHINGTON

19. (a) APR 1 - 1943 (Date received local registrar) (b) J. F. Bulick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL 13 day year 1943 hour 1:40 minute A. M.

21. I hereby certify that I attended the deceased from JAN. 27, 1943, to APRIL 13, 1943; that I last saw him alive on APRIL 13, 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hodgkins disease (lymphogranulomatosis)	1 yr.
Due to:	
Due to:	
Other conditions: none (Include pregnancy within 3 months of death)	

Major findings: Of operations: Biopsy lymph node showed Hodgkins

Of autopsy: confirmed above.

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: F R Bradley (M. D. or other)

Address: BARNES HOSPITAL Date signed: 4/13/43

(Licensed Embalmer's Statement on Reverse Side)

3516

3516

STATEMENT BY [redacted]ENSED 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 Albert H Hopper

Licensed Embalmer No. 186

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.