

S. No. 2
M-542
V. 5-1
P. I 2273

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30097**
8233
Registrar's No.

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

FILED SEP 21 1943 318

Registration District No. _____ Primary Registration District No. **1003**

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:
St. Mary's Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days**
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO 11L** (b) County **ST. CLAIR 11**
(c) City or town **East St. Louis**
(If outside city or town limits, write "RURAL") **NR**
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Victor Keyes**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **Col.** 6. (a) Single, widowed, married, divorced **Child**

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

7. Birth date of deceased **Sept. 4 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 10 hr. _____ min.

9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Child**

11. Industry or business _____

12. Name **Victor Keyes**

13. Birthplace **Miss.**
(City, town, or county) (State or foreign country)

14. Maiden name **Estella Jones**

15. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Victor Keyes**

(b) Address **2430 1/2 Mo. Ave. E. St. Louis, Ill.**

17. (a) **Removal** (b) Date thereof **9/15/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Clair County, Ill.**

18. (a) Signature of funeral director **R.M.C. Green**

(b) Address **3517 Laclede Ave**

19. (a) **SEP 13 1943** (b) _____
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **14**
year **1943** hour **1** minute **0** M.

21. I hereby certify that I attended the deceased from **9-4-43**
_____ 19____ to **9-14** 19**43**
that I last saw him **alive on 9-14** 19**43**;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Asphyxia
Due to **Enlarged Thyroid**
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death) **64**

Major findings:
Of operations _____
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)
Means of injury _____
23. Signature **J. H. ...** (M. D. or other)
Address **1500 E. Broadway** Date signed **9/17/43**

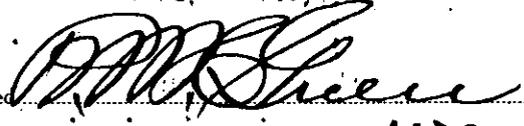
Duration **10 days**
Butt
PHYSICIAN
Underline the cause to which death should be charged statistically.

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. 1175

P. O. Address 3517 S. Leland Av

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.