

FILED MAR 27 1944 318

1005

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2547

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

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4256 Maryland
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Nellie A. Keoughan
 3. (b) If veteran, name war _____
 3. (c) Social Security No. Unk.

4. Sex Female / race White
 5. Color or race _____
 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: August 11 1873
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 7 5 hr. _____ min.

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

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER {
 12. Name Walter Keoughan
 13. Birthplace Unknown Ireland
 (City, town, or county) (State or foreign country)
 14. Maiden name Margaret Buggy
 15. Birthplace Unknown Ireland
 (City, town, or county) (State or foreign country)

16. (a) Informant Charles Misegades
 (b) Address 4256 Maryland Ave.

17. (a) Removal (b) Date thereof 3-17-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carrollton, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) J. F. Brudeck (b) J. F. Brudeck
 (If involved local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16
 year 1944 hour 8:45 minute A. M.
 21. I hereby certify that I attended the deceased from 2-26-44
 1944 to 3-16 1944
 that I last saw her alive on 3-15 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of small intestine and mesentery.
 Due to Primary site in small intestine
 Due to _____
 Other conditions: none
 (Include pregnancy within 3 months of death)

Duration _____
 PHYSICIAN _____

Major findings: Carcinoma involving mesentery and about 80% of small intestine. Remnant of autopsy.
Results of surgery plus small pieces of specimen.

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) no
 (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 John J. Hammond (M.D. or other) M.D.
 Address 434 N Grand Date signed 3/16/44

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

MAR 16 1944

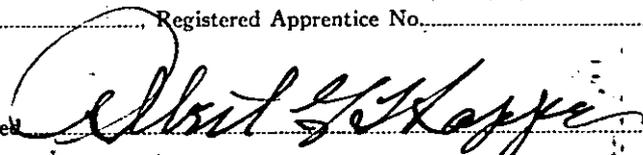
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

..... Registered Apprentice No.....

Signed



..... Licensed Embalmer No. 2971

..... 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.