Form No. 2
M—5-43
7. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 30 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31424

Registration District No. 367 Primary Registration District No. 6076 Registrar's No. 1983

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Mother of Good Counsel Home
(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 Missouri (b) County .....

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

(d) Street No. 6112 McPherson
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Julia C. Keane

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

4. Sex Female 5. Color or race White 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 September (Month) 22 (Day) 1872 (Year)

8. AGE: Years 74 Months -- Days 1 If less than one day ..... hr. ..... min.

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

10. Usual occupation At Home

11. Industry or business .....

MOTHER FATHER

12. Name William Keane

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

14. Maiden name Mary McClean

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

16. (a) Informant Mrs. E. J. Costigan

(b) Address 4540 Lindell Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 - 25 - 46 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Chas. F. Stuart

(b) Address 1225 Union Blvd.

19. (a) 9-25-46 (Date received local registrar) (b) Ruth Colleen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 23rd year 1946 hour 1:30 minute A.M.

21. I hereby certify that I attended the deceased from July 15 1946 to Sept 23 1946 that I last saw her alive on Sept 21 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral arteriosclerosis	1 yr
Due to: senility	
Due to: 82	
Other conditions: (Include pregnancy within 3 months of death) Chronic Myelitis (cause unknown)	20 yrs

Major findings:
Of operations No
Of autopsy No

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) 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? — (Specify type of place)

While at work? ..... (e) Means of injury 0

23. Signature Wm J Langan Jr (M. D. or other)

Address 5803 Raymond Ave Date signed Sept 23/46

(Licensed Embalmer's Statement on Reverse Side)

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

30255

JAN 2 1947

OCT 17 1946

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.