

No. 2  
12-45  
17-39  
X47070

FILED MAR 6 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 74150  
Registrar's No. 466

Registration District No. 37

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Rural Wellston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Vincent's Sanitarium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: 3 months 2 days (Specify whether  
In this community 3 months 2 days  
years, months or days)

3. (a) PRINT FULL NAME MR. WILLIAM KEANEY  
3. (b) If veteran, name war ..... 3. (c) Social Security No. ....

4. Sex Male 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 March 27 1887  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
59 11 2 hr. min.

9. Birthplace County Mayo Ireland  
(City, town, or county) (State or foreign country)

10. Usual occupation Farm Work

11. Industry or business .....

MOTHER FATHER:  
12. Name Mr. Hugh Keaney  
13. Birthplace County Mayo Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Bridget Keaney  
15. Birthplace County Mayo Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant SISTER MARY LOUIS  
(b) Address ST VINCENT SANITARIUM

17. (a) BURIAL (b) Date thereof 3-3-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Gullen-Kelly  
(b) Address 7267 Nail Bridge Rd. St. Louis

19. (a) 3-4-47 (b) W. B. L. Hon  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Rural Wellston  
(If outside city or town limits, write "RURAL")  
(d) Street No. .... (If rural, give location)  
(e) Citizen of foreign country? ..... (Yes or No)  
If yes, name country .....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 1  
year 1947 hour 2 minute 45 A. M.

21. I hereby certify that I attended the deceased from NOV. 26, 1946 to March 27, 1947.  
that I last saw him alive on 2-28, 1947,  
and that death occurred on the date and hour stated above.

Immediate cause of death CARCINOMA OF PHARYNX AND ESOPHAGUS(?) ASSOCIATED 2 MASSIVE HEMORRHAGE  
Due to CORONARY OCCLUSION(?)  
45 hr

Other conditions: .....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations .....  
Of autopsy .....

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?

While at work? ..... (Specify type of place)  
(e) Means of injury .....

23. Signature W. B. L. Hon (M. D. or other) 0  
Address St. Vincent's Sanitarium Date signed 3/1/47

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

**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.....

*James A. Lemmers*

Licensed Embalmer No.....

*4142*

P. O. Address.....

*St. Louis*

**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.**