S. No. 2
M—1/47
v. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27379

FILED SEP 15 1947

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 780

39
2
6

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

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: O'Reilly VAH
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6-19-47 to 9-4-47 (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County 999
(c) City or town Belleville 11
(If outside city or town limits, write "RURAL")
(d) Street No. 204 S. Pennsylvania Ave. 0
(If rural, give location) 2
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME ARTHUR J. MCKEOGH
3. (b) If veteran, name war WW I
3. (c) Social Security No. None
4. Sex M O
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Mrs. Cora E. McKeogh
6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased 10-28-97 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	49	10	6	..... hr. ..... min.

9. Birthplace New York, N. Y. (City, town, or county) (State or foreign country)
10. Usual occupation Stock Broker
11. Industry or business .....
FATHER
12. Name James McKeogh
13. Birthplace New York, N. Y. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Anna Dolan
15. Birthplace Ireland (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Cora E. McKeogh
(b) Address Belleville Ill
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 5-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Belleville Ill.
18. (a) Signature of funeral director Lyman Schaaf Funeral Home
(b) Address Springfield Mo
19. (a) 9-4-47 (Date received local registrar) (b) W E Handley WD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 4
year 1947 hour 3 minute 10 P.M.
21. I hereby certify that I attended the deceased from 6-19-47
..... 19..... to 9-4- 19 47;
that I last saw him alive on September 4 19 47;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tuberculosis, pulmonary, bilateral, chronic, far advanced	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause of 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) 0
While at work? (e) Means of injury .....
23. Signature Paul Eccle (M. D. ~~or other~~)
Address Springfield Mo Date signed 9-4-1947

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

DEC 29 1948

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 L. Stanley Forman

Licensed Embalmer No. 3177

P. O. Address Springfield, Mo

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.