

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

27889

FILED AUG 28 1948

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

7184

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:
203 N. Third St.
(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) 54 years.
In this community _____

3. (a) PRINT FULL NAME BARNARD C. KEITH

3. (b) If veteran, name war None 3. (c) Social Security No. None

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 August 7, 1874
(Month) (Day) (Year)

8. AGE: Years 74 Months 0 Days 8 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired Physician

11. Industry or business _____

12. Name Clayton Keith
13. Birthplace Chillicothe Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Mary Barnard
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant W. F. Keith
(b) Address 203 N. Third St.

17. (a) Cremation (b) Date thereof August 17, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Wagoner Montuary
(b) Address 4161 Lindell Blvd.
AUG 16 1948

19. (a) _____ (b) J. P. Bredesch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 203 N. Third St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15th year 1948 hour 1:23 PM minute _____ M. _____

21. I hereby certify that I attended the deceased from Aug 13th 1948, to August 15th 1948;
that I last saw him alive on Aug 15th 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Hay fever, congestion of lungs, pneumonia, lobes Duration _____
Due to Has had hay fever nearly every year (in Aug) since about 4 yrs ago
Due to _____

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? _____

(Specify type of place)
While at work? _____ (c) Means of injury _____

23. Signature W. F. Keith M.D. (M. D. or other) _____
Address 203 N. Third St. Date signed 8/15/48

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

NOV 19 1953

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 Robert T. Sangster

Licensed Embalmer No. 4290

P. O. Address St Louis, 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.