FEDERAL SECURITY AGENCY
National Office of Vital Statistics

#91938

FILED DEC 8 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38303

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10319

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether
In this community
years, months or days)

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. 5300 Arsenal
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country --

3. (a) PRINT FULL NAME JAMES KEEGAN

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Deceased

6. (c) Age of husband or wife if alive years

7. Birth date of deceased October 27, 1862
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
86	0	29	hr. min.

9. Birthplace St. Louis, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business

FATHER
12. Name John Keegan
13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown 4
(City, town, or county) (State or foreign country)

16. (a) Informant James F. Keegan
(b) Address 6030 Lucille

17. (a) Burial (b) Date thereof Nov 29 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Bromschwig and Son Funeral Home
(b) Address 4746 W. Florissant Ave.

19. (a) NOV 28 1948 (b) J B Lasater
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25th
year 1948 hour 9 minute 43 P M.

21. I hereby certify that I attended the deceased from 11/20/48
, 19 ; to Nov. 25th, 1948
that I last saw him alive on Nov. 25th, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Bleeding acute peptic ulcer duodenum — Duration 2 4 days

Due to

Due to 117a

Other conditions Chronic abscess peri-cholecystic
(Include pregnancy within 3 months of death)

Major findings:
Of operations Normal retrocecal appendix
Of autopsy as above

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? D
(Specify type of place)

While at work? (e) Means of injury

23. Signature J M Donald J W Bassett MD
1515 Lafayette 11/26/48 (M.D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 me

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

working under my personal supervision.

Signed Guy W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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-3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dee

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10319

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:
(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 (b) County

(c) City or town
(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

3. (a) PRINT FULL NAME James Keegan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct (Month) 27 (Day) 1862 (Year)

8. AGE: Years 86 Months 0 Days 29 If less than one day hr. min.

9. Birthplace (City, town, or county) No (State or foreign country)

10. Usual occupation none

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 12-9-48 (Date received local registrar) (b) J B Lesster (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 25
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
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? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-38303