

FILED JAN 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2880

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **251**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <b>6163 Kingsbury Blvd.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Stone Nursing Home</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Mary E.</b> b. (Middle) <b>Keeshan</b> c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 10, 1949</b>
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5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>S.</b>	8. DATE OF BIRTH <b>1869</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Days	IF UNDER 2 HRS. Hours	IF UNDER 2 HRS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>St. Louis</b>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <b>William Keeshan</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Keeshan (nee)</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>John Keeshan, 6926 Pershing Ave.</b>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart Disease</b>		<b>2 years.</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>General Arteriosclerosis</b>		<b>5 years.</b>
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>None</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None</b>	21b. PLACE OF INJURY (e.g., 1307 1/2 street home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>None</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Aug**, 19**46**, to **Sept**, 19**48**, that I last saw the deceased alive on **Sept**, 19**48**, and that death occurred at **6:00 A.** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Walter W. Davis, M.D.</b>	(Degree or title)	23b. ADDRESS <b>539 N. Grand Ave.</b>	23c. DATE SIGNED <b>Jan 10, 1949</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>1-12-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>JAN 10 1949</b>	REGISTRAR'S SIGNATURE <b>J. B. Kessler</b>	EMERALD DIRECTOR'S SIGNATURE <b>Arthur J. Donnelly</b>	ADDRESS <b>6840 Lindell Blvd.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Mr. Wm. W. Miller  
Humboldt, Oregon

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed W W Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

**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.