

THE DIVISION OF HEALTH OF MISSOURI

FILED APR 2 1949 STANDARD CERTIFICATE OF DEATH

State File No. 10903

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 536

1. PLACE OF DEATH a. COUNTY <u>St Louis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirkwood</u>	
c. LENGTH OF STAY (In this place) <u>8 Days</u>		d. STREET ADDRESS (If rural, give location) <u>319 Caroline</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Louis County Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Stacey</u>	b. (Middle)	c. (Last) <u>Kean</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>3 6 49</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, (DIVORCED) (Specify) <u>h</u>	8. DATE OF BIRTH <u>3-15-1897</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>21</u>	IF UNDER 2 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>John Kean</u>	13b. MOTHER'S MAIDEN NAME <u>Lee BALLEW</u>	14. NAME OF HUSBAND OR WIFE <u>Ruth Stoker Kean</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Hospital Records St Louis Co Hospital</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Lobar pneumonia. Arteriosclerotic heart disease</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>4/9/49</u> <u>930</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>0</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St Louis Co, Missouri</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 2/26, 1949, to 3/6, 1949, that I last saw the deceased alive on 3/5, 1949, and that death occurred at 12:25 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr Wood M. D.</u>	23b. ADDRESS <u>St. Louis County Hospital</u>	23c. DATE SIGNED <u>3/6/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>3/8/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St Louis County</u>
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DATE REC'D BY LOCAL REG. <u>3-7-49</u>	REGISTRAR'S SIGNATURE <u>Shirley L. Jennings</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>JAY B. SMITH 7456 MANCHESTER</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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322

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

*H. P. Burgess*

Licensed Embalmer No. \_\_\_\_\_

4029

P. O. Address \_\_\_\_\_

Maplewood

**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.