

FILED MAY 4 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13647  
State File No. 3739  
Registrar's No. 3739

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH  
a. COUNTY Mo ST LOUIS

b. CITY (If outside corporate limits, write RURAL and give township) ST LOUIS  
c. LENGTH OF STAY (in this place) 3 DA  
c. CITY OR TOWN CHARLACK  
d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION FAITH Hosp  
e. STREET ADDRESS (If rural, give location) 2804 ENDICOTT

3. NAME OF DECEASED  
a. (First) Floyd  
b. (Middle) KEATING  
c. (Last) KEATING  
4. DATE OF DEATH (Month) (Day) (Year) 4-25-54

5. SEX Male  
6. COLOR OR RACE White  
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED  
8. DATE OF BIRTH APR 16 1896  
9. AGE (in years last birthday) 58  
If UNDER 1 YEAR: Months Days  
If UNDER 2 WRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOREKEEPER  
10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.  
11. BIRTHPLACE (City and State or Foreign Country) GREENFIELD IOWA  
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME SAMUEL KEATING  
13b. MOTHER'S MAIDEN NAME ELIZ CAVANESS  
14. NAME OF HUSBAND OR WIFE VIVIAN KEATING

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  
16. SOCIAL SECURITY NO.  
17. INFORMANT'S SIGNATURE OR NAME ADDRESS VIVIAN KEATING 2804 ENDICOTT

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)  
MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) At Labor Pneumonia  
INTERVAL BETWEEN ONSET AND DEATH 48 hrs  
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.

19a. DATE OF OPERATION  
19b. MAJOR FINDINGS OF OPERATION  
20. AUTOPSY? YES  NO

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) 490X

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.  
21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK   
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-23-54, to 4-25-54, that I last saw the deceased alive on 4-25-54, and that death occurred at 7:25 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Anthony V. Benincosa MD  
23b. ADDRESS 3731 Sandfellow Blvd  
23c. DATE SIGNED 4-25-54

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL  
24b. DATE 4-26-54  
24c. NAME OF CEMETERY OR CREMATORY GREENFIELD CEM  
24d. LOCATION (City, town, or county) (State) GREENFIELD IOWA

DATE REC'D BY LOCAL REG. APR 28 1954  
REGISTRAR'S SIGNATURE Carl Smith MD  
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS ORTMANN F Home 9222 Backland

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

**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.....  
Signature of Student Embalmer

Signed... *Al C Ortman* .....

Licensed Embalmer No. *34*

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.