

FILED APR 30 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13771**

BIRTH NO. _____ REG. DIST. NO. **159** PRIMARY REG. DIST. NO. **4249** Registrar's No. **33**

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hillsboro Mo.		c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Ceder Grove Nurseing Home		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS 4103 a W. Lee		21071	

3. NAME OF DECEASED (Type or Print) a. (First) Lawrence b. (Middle) R. c. (Last) Keough			4. DATE OF DEATH (Month) (Day) (Year) 4 18 56		
---	--	--	---	--	--

5. SEX M	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 24, 1913	9. AGE (In years last birthday) 42	IF UNDER 1 YEAR Months _____	IF UNDER 2 HRS. Days _____	Hours _____	Min. _____
-----------------	----------------------------	---	---------------------------------------	---	------------------------------	----------------------------	-------------	------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Finisher		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? USA.	
--	--	---	--	---	--	--	--

13a. FATHER'S NAME Michael Keough		13b. MOTHER'S MAIDEN NAME Catherine Leahy		14. NAME OF HUSBAND OR WIFE Mabel Keough	
--	--	--	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 490-05-0962		17. INFORMANT'S SIGNATURE OR NAME Mabel Keough ADDRESS 4103 a W. Lee	
---	--	--	--	--	--

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 6 wks
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Decompensation	ANTECEDENT CAUSES			
	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) Valvular insufficiency		
		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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--	--

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) 4214	
--	--	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
--	--	----------------------------	--

22. I hereby certify that I attended the deceased from **Mar 1, 1956**, to **4-18, 1956**, that I last saw the deceased alive on **4-15, 1956**, and that death occurred at **3:45 Am.**, from the causes and on the date stated above.

23a. SIGNATURE John W. Danke MD (Degree or title)	23b. ADDRESS 3606 Gravois St. Louis Mo.	23c. DATE SIGNED 4-18-56
--	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/20/56	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
---	--------------------------	--	--

DATE REC'D BY LOCAL REG. 4-19-56	REGISTRAR'S SIGNATURE Kathleen Marsden	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert D. Kinealy 2228 St. Louis Ave	
---	---	--	--

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

JEFFERSON COUNTY HEALTH DEPT.
HILLSBORO, MISSOURI

DATE RECEIVED

APR 23 1956

MAY 16 1956

9561 & 1 NOV 1

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 *Francis J. Wyland Jr.*

Licensed Embalmer No. *451*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.