

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28112**
19

FILED SEP 6 1956

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No.

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

1. PLACE OF DEATH a. COUNTY St. Louis MO		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO		b. COUNTY	
b. CITY OR TOWN St. Louis MO	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION City Warehouse			e. STREET ADDRESS (If rural, give location) 28 WUR 22590		

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) c. (Last) Keogh		4. DATE OF DEATH (Month) (Day) (Year) 18 36		
5. SEX M COLOR W RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 1901	9. AGE (in years less than last birthday) 35 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) WUR	10b. KIND OF BUSINESS OR INDUSTRY WUR	11. BIRTHPLACE (City and State or Foreign Country) WUR	12. CITIZEN OF WHAT COUNTRY? WUR	

13a. FATHER'S NAME WUR	13b. MOTHER'S MAIDEN NAME WUR	14. NAME OF HUSBAND OR WIFE WUR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or name of service) WUR	16. SOCIAL SECURITY NO. WUR	17. INFORMANT'S SIGNATURE OR NAME V. O. Vaughn ADDRESS 1300 Clark	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	DUE TO (b)		
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	DUE TO (c) Ruptured Heart		
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 checked="" type="checkbox"/> NO <input 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)
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Deceasee or title) James M Keely	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 7-28-51
---	--------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) WUR	24b. DATE 8-31-56	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
--	--------------------------	--	---

DATE REC'D BY LOCAL REG. AUG 21 1956	REGISTRAR'S SIGNATURE Charles Smith	25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service ADDRESS 4104 Manchester Ave. St. Louis, Mo.
---	--	--

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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**