

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-023600  
STATE FILE NUMBER

FILED JUL 1 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6075

S. 300  
1-57

|   |                             |   |  |  |   |
|---|-----------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                             |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN St. Louis, Mo.  |                             | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN St. Louis  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                         |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION 6519 Morganford  |                             | Length of stay in 1b<br>2629  | d. STREET ADDRESS (If outside, give location)<br>6519 Morganford   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                        |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>Lillie O'Keefe   |                             |   | 4. DATE OF DEATH<br>Month Day Year<br>June 13, 1958  |  |   |
| 5. SEX<br>female  | 6. COLOR OR RACE<br>white   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>25 Dec. 1893   | 9. AGE (In years<br>1st birthday)<br>64                                | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife  |                             | 10b. KIND OF BUSINESS OR INDUSTRY<br>at home  | 11. BIRTHPLACE (City and state or country)<br>St. Louis, Mo. 0   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |
| 13a. FATHER'S NAME<br>Charles Eyermann  |                             | 13b. MOTHER'S MAIDEN NAME<br>Barbara Fehmel   |  | 14. NAME OF HUSBAND OR WIFE<br>Edward O'Keefe                          |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes or unknown) (If yes, give year or dates of service)<br>none none   |                             | 16. SOCIAL SECURITY NO.   | 17. INFORMANT<br>Address<br>Robert Eyermann 6331 Vermont   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause possible for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>External Hemorrhage</i>   |                             |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____   |                             |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| DUE TO (c) _____ <i>E977x</i>   |                             |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |                             |   |  |  |   |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>  |                             | 20b. DESCRIBE HOW INJURY OCCURRED (For cause of injury, see PART I or PART II of item 18.)<br><i>Following slashing of wrist with a pocket knife</i>          |  |  |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. 6 12 58<br>p.m.  |                             | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, office, etc.)<br><i>Home</i>   |  |  |   |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                             | 20f. CITY, TOWN OR LOCATION COUNTY STATE<br><i>St. Louis Mo.</i>  |  |  |   |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____<br>Death occurred at _____ <i>215A</i> _____ on the date stated above; and to the best of my knowledge, from the causes stated. |                             |   |  |  |   |
| 22a. SIGNATURE<br><i>James M. Kelly</i> (Degree or title) <i>Deputy Coroner</i>   |                             | 22b. ADDRESS<br><i>3130 Clark</i>   |  | 22c. DATE SIGNED<br><i>6-13-58</i>                                     |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>burial</i>  | 23b. DATE<br><i>6-16-58</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>New St. Marcus C.m.</i>  |  | 23d. LOCATION (City, town, or county) (State)<br><i>St. Louis, Mo.</i> |   |
| 24. FUNERAL DIRECTOR<br><i>Southern Funeral Home</i><br>ADDRESS<br><i>6322 S. Grand, St. Louis, Mo.</i>   |                             | 25. DATE RECD. BY LOCAL REG.<br><i>JUN 13 1958</i>  |  | 26. REGISTRAR'S SIGNATURE<br><i>J. Carl Smith MD</i><br><i>mjb.</i>    |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *David Van Fossan* .....

Licensed Embalmer No. *4342*  
P. O. Address *St Louis Mo* .....

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.