

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023067

STATE FILE NUMBER

2 5369

FILED JUN 24 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.		d. STREET ADDRESS 2846 Arlington Ave.	
Length of stay in lb 3 days		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle F. Last Keane			4. DATE OF DEATH Month 6 Day 4 Year 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1878
9. AGE (In years last birthday) 80		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) Railway Clerk-Ret.		10b. KIND OF BUSINESS OR INDUSTRY Express	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Thomas Keane		13b. MOTHER'S MAIDEN NAME Elizabeth unknown	
14. NAME OF HUSBAND OR WIFE Ethel Keane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ethel Keane, 2846 Arlington Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL-THROMBOSIS			INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIO-SCLEROTIC HYPERTENSIVE			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
DUE TO (c) HEART DISEASE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ADVANCED EMPHYSEMA			4200
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from APRIL, 1959 to JUNE 4, 1959 and last saw ^{her} him alive on JUNE 3, 1959 Death occurred at 6:45 a m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Joseph R. Maciver M.D. (Degree or title)		22b. ADDRESS 634 NORTH GRAND	
22c. DATE SIGNED 6-5-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 6/6/59	
23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cem.		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
24. FUNERAL DIRECTOR Drehmann-Harral		ADDRESS 1905 Union	
25. DATE RECD. BY LOCAL REG. JUN 5 '59		26. REGISTRAR'S SIGNATURE Roald Smith, M.D.	

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

S. 300
1-57
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mjs

Dr. J. R. Macko
Mo. Theatre Bldg.
01. 2-0635

Hrs. 10 - 1 P.M.

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 *Albert R Thompson*

Licensed Embalmer No. *4257*

P. O. Address *St. J. ...*

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.