

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023068

FILED JUN 19 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ STATE FILE NUMBER 4820 Registrar No. 4820

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kirkwood 4640</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>		Length of stay in lb. <b>2-mon.</b>	d. STREET ADDRESS (If outside, give location) <b>10341 Manchester Road</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Joseph</b> Last <b>Keefe</b>			4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1959</b>		
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 20, 1877</b>	9. AGE (In years last birthday) <b>81</b>	10. FUNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Advt. Director, Chrysler Corp.</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Michael Keefe</b>		13b. MOTHER'S MAIDEN NAME <b>Mary McNamara</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Emma Keefe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Mr. Robert Carmody, 9709 Greystone, Rock Hill</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ <b>Adams-Stroke Syndrome (cardiac)</b> <b>Arterio-sclerotic heart disease</b> <b>standstill</b> <b>10 min.</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 WORK <input type="checkbox"/> NOT WHILE 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 <b>March 5, 1959</b> and last saw him alive on <b>May 17, 1959</b> Death occurred at <b>2:30 pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>David B. Javan M.D.</b>			22b. ADDRESS <b>539 N. Grand St. St. Louis</b>		22c. DATE SIGNED <b>5/18/59</b>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 19, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>	
				23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR <b>Arthur J. Donnelly</b>			ADDRESS <b>3840 Lindell Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 18 '59</b>
26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>					

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 Williamson* .....

Licensed Embalmer No. *3565*  
P. O. Address *3840 Lind*

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.