

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030534

15 AUG 24 1959

2 7489

STATE FILE NUMBER

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)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		a. STATE <b>MISSOURI</b>	b. COUNTY _____
Length of stay in 1b <b>21 DAYS</b>		c. CITY OR TOWN <b>ST LOUIS</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7221 MINNESOTA</b>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
<b>MOSES</b>			<b>M.</b>	<b>KEENEY</b>	<b>KEENEY</b>	<b>AUGUST</b>	<b>11</b>	<b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB-3-1902</b>	9. AGE (last birthday) <b>57</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>8</b> Hours _____ Min. _____		IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE MAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ST LOUIS CARBON</b>		11. BIRTHPLACE (City and state or country) <b>RELFH, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>DANIEL KEENEY</b>			13b. MOTHER'S MAIDEN NAME <b>ALICE AYERS</b>			14. NAME OF HUSBAND OR WIFE <b>RUTH KEENEY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO NONE</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>RUTH KEENEY</b> Address <b>7221 MINNESOTA AV. ST LOUIS MO.</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>GASTROINTESTINAL HEMORRHAGE</b>		<b>1 WEEK</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>APLASTIC ANEMIA</b>	<b>2 MONTHS</b>
	DUE TO (c) <b>292.4</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>BRONCHOPNEUMONIA</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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 _____ a.m. _____ p.m.	Month, Day, Year				
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 **JULY 30, 1959** to **AUGUST 11, 1959** and last saw her/him alive on **AUGUST 11, 1959**  
Death occurred at **1:40 A.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i> (Degree or title) <b>M. D.</b>		22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>8/11/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>AUG 12 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GIRARD CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>GIRARD, KANSAS.</b>
24. FUNERAL DIRECTOR <b>FEY FUNERAL HOME, MENHILLE MO</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 12 '59</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i> <b>M. D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Paul E Morris

Licensed Embalmer No. 3360

P. O. Address St Louis 7

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.