

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037751

FILED VS OCT 19 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9163** STATE FILE NUMBER

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		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5403 Ruskin Ave.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5403 Ruskin Ave.			
3. NAME OF DECEASED (Type or print) First GERALD Middle J. Last KEATING				4. DATE OF DEATH Month Oct. Day 3 Year 1959					
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 5/26/1906			
				9. AGE (last birthday) 53		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) police officer			10b. KIND OF BUSINESS OR INDUSTRY law Enforcement		11. BIRTHPLACE (City and state or country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME James Keating			13b. MOTHER'S MAIDEN NAME Schehan			14. NAME OF HUSBAND OR WIFE Madeline Keating			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Address Madeline Keating 5403 Ruskin				
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) Infection of Myocardium							10 minutes		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) Arteriosclerotic Coronary Thrombosis 10 minutes		
DUE TO (c) Arteriosclerotic Heart Disease							6 to 12 mos.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. 420.0 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) 420.0					
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 8/25/59 to 10/3/59 and last saw ^{her} him alive on 10/1/59 Death occurred at 3:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Dr. Lester A. Flotte M.D.				22b. ADDRESS 8700 Riverview Blvd				22c. DATE SIGNED 10/5/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 10/8/59		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis		STATE Mo.	
24. FUNERAL DIRECTOR Buchholz Mortuary 5967 W. Florissant				25. DATE RECD. BY LOCAL REG. OCT 6 '59		26. REGISTRAR'S SIGNATURE Carl Smith M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

acc.

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 Walter J. B. [Signature]

Licensed Embalmer No. 4557

P. O. Address [Signature]

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.