

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59 046408

FILED VS. JAN - 8 1960 317

Registration District No. \_\_\_\_\_ Primary Registration District No. 500 Registrar's No. 3284 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b>		Length of stay in 1b <b>5 Weeks</b>		c. CITY OR TOWN <b>St. Louis</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>Charles The 1st Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5605 Potomac St.</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle _____ Last <b>KEADY</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>8</b> Year <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>3-21-1871</b>	9. AGE (last birthday) <b>88</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Plumber-Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>		11. BIRTHPLACE (City and state or country) <b>IRELAND.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Thomas Keady</b>			13b. MOTHER'S MAIDEN NAME <b>Julia Thornton</b>			14. NAME OF HUSBAND OR WIFE <b>Mary Keady</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>Thomas Keady 5636 Potomac St.</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) <b>Cerebral Hemorrhage (apoplexy)</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10/31/57.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arterio Sclerosis</b>							<b>4 yrs +</b>
DUE TO (c) <b>Fracture</b>							<b>4 yrs +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>331x</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 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.) <b>331x</b>			
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 <b>8/19/55</b> to <b>12/8/59</b> and last saw <sup>her</sup> him alive on <b>12/2/59</b> . Death occurred at <b>9:30 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Robert P. Smith MD</b>				22b. ADDRESS <b>5203 Chiffware Dr</b>		22c. DATE SIGNED <b>12/8/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 11, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis Co/ Mo</b>		(State)
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway</b>				25. DATE RECD. BY LOCAL REG. <b>12-9-59</b>		26. REGISTRAR'S SIGNATURE <b>John B. [Signature]</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS NOV 22 1930

**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 R. W. Stovessand

Licensed Embalmer No. 4007

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.