

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028503

FILED VS. JUL 22 1960 318

1003

6977

STATE FILE NUMBER

INDEXED

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 8 yrs.	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardinal Glennon Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 8558 Oriole Ave.
3. NAME OF DECEASED (Type or print) CAROL		First Middle Last KEHOE	4. DATE OF DEATH Month JULY Day 11 Year 1960
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 23, 1952
9. AGE (last birthday) 8 yrs	IF UNDER 1 YEAR Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY St. Louis, Mo
11. BIRTHPLACE (City and state or country) St. Louis, Mo	12. CITIZEN OF WHAT COUNTRY U. S.	13a. FATHER'S NAME John J. Kehoe	13b. MOTHER'S MAIDEN NAME Lorraine Rechten
14. NAME OF HUSBAND OR WIFE none	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 John J. Kehoe
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LEUKEMIA	DUE TO (b)	DUE TO (c) 2043	INTERVAL BETWEEN ONSET AND DEATH 13 months
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. <input type="checkbox"/> Yes <input checked="" 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"/> None	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 JULY 1959 to JULY 11, 1960 and last saw her alive on JULY 10, 1960 Death occurred at 12:22 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James P. King M.D.	22b. ADDRESS 1465 S. GRAND AVENUE	22c. DATE SIGNED 7/11/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 13, 1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cem.	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Morrell Mortuary	ADDRESS 3710 North Grand	25. DATE RECD. BY LOCAL REG. JUL 12 1960	26. REGISTRAR'S SIGNATURE Loed Smith, M.D. <i>mgs</i>

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 Lorou E. Percy

Licensed Embalmer No. 4094

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.