

FEDERAL BUREAU OF INVESTIGATION  
 DIVISION OF HEALTH STANDARDS  
 STANDARD CERTIFICATE OF DEATH

60-028504  
 STATE FILE NUMBER

INDEXED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **7704**

318 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b -----	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>BARNES HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5248 Maffitt Avenue, 13,</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>HANNAH</b> Middle <b>KEIGHER</b> Last			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>2</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-27-1874</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>(U) CASPER HENRY ROLF</b>		13b. MOTHER'S MAIDEN NAME <b>MARIE E. HESKER</b>		14. NAME OF HUSBAND OR WIFE <b>Late John Keigher</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>488-34-4337</b>		17. INFORMANT Address <b>Mrs. Eileen Schrier, RR # 1, Box 654, Maryland Heights, 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 LAST DEATH <b>2 WEEKS</b>
IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b>		YEARS ?
Conditions, if any, to which give rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>HYPERTENSIVE AND ARTERIOSCLEROTIC HEART DISEASE</b>	
	DUE TO (c) <b>443X</b>	
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 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.)	
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 18, 1960** to **AUGUST 2, 1960** and last saw her/him alive on **AUGUST 2, 1960**  
 Death occurred at **12:35 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. O. Vermillion, M.D.</i> (Degree or title)	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>8/2/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-6-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>
23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>		(State)

24. FUNERAL DIRECTOR <b>CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., FUNERAL HOME, St. Louis, 15, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 4 1960</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH SERVICES

**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 Ralph C. Zindler

Licensed Embalmer No. 4228

P. O. Address St. Louis

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.