SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-018686
STATE FILE NUMBER

AMENDED

FILED JUN 13 1961

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 139

DATE AMENDED | INSTEAD OF | DOCUMENT | SHOULD READ | BY AFFIDAVIT OF | ITEM NO.

1. PLACE OF DEATH
a. COUNTY St. Charles
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles — Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 200a No. Main St. — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St.Charles
c. CITY OR TOWN St. Charles Twsp. — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) R.R.#1,Kampsville — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Ida Middle Gertrude Last Keane
4. DATE OF DEATH Month Jun. 6, Day 1961 Year

5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH Feb.22,1895
9. AGE (last birthday) 66 — IF UNDER 1 YEAR Months 3 Days 14 — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse R.N.
10b. KIND OF BUSINESS OR INDUSTRY Private
11. BIRTHPLACE (City and state or country) Cook County,Ill.
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Elias Andres
13b. MOTHER'S MAIDEN NAME Anna M. Verstandic
14. NAME OF HUSBAND OR WIFE Joseph Keane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
17. INFORMANT Address Mrs.Louise Stewart,St. Charles, County,Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 1yr 7mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension
DUE TO (c)
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Nov. 22 1960, to June 6th and last saw her alive on June 6th 1961
Death occurred at 2.15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Dr. N. H. Eyler M.D.
22b. ADDRESS 200a N. Main St St Charles Mo
22c. DATE SIGNED 6/7/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Jun. 9, 1961
23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis County,Mo.

24. FUNERAL DIRECTOR ADDRESS H.C.Dallmeyer & Sons,St. Charles, Mo.
25. DATE RECD. BY LOCAL REG. June 7-61
26. REGISTRAR'S SIGNATURE Marcella Wilson

(Licensed Embalmer's Statement on Reverse Side)

JUN 14 1961

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 Frank R Amalon

Licensed Embalmer No. 4832

P. O. Address J. N. Charles

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.