

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5353** = **61-022783**
 STATE FILE NUMBER

AMENDED # **FILED JUN 16 1961**

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 (11)		c. CITY OR TOWN St. Louis (11)	
Length of stay in 1b Life		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 921 Eichelberger Ave.		d. STREET ADDRESS (If outside, give location) 921 Eichelberger Ave.	
Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

3. NAME OF DECEASED (Type or print) First William Middle J Last Keith			4. DATE OF DEATH Month June Day 6 Year 1961		
---	--	--	---	--	--

5. SEX Male	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 9/14/72	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
--------------------	-------------------------------	--	---------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Passenger Agent	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Lexington Mo.	12. CITIZEN OF WHAT COUNTRY USA
--	--	---	--

13a. FATHER'S NAME George G Keith	13b. MOTHER'S MAIDEN NAME Mollie Jenkins	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 Address Armand Bosso 461 Bellerive 11
---	-------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion.		INTERVAL BETWEEN ONSET AND DEATH 2 days
DUE TO (b) Coronary myocardi.		
DUE TO (c) Secondary 420.1		
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 **5:30 9-9** to **6/6/1961** and last saw her/him alive on **June 4-61**
 Death occurred at **6 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Armand Bosso (Degree or title)	22b. ADDRESS 506 Olive St	22c. DATE SIGNED 6/8/61
--	----------------------------------	--------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/9/61	23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery	23d. LOCATION (City, town, or county) (State) Lemay Mo.
--	-------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS Fendler Und. Co. 7420 Michigan 11	25. DATE RECD. BY LOCAL REG. JUN 8 1961	26. REGISTRAR'S SIGNATURE Lead Smith. M.D.
---	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Martin J. Glaser
506 Clark St.
Chgo 1-5028

Mr. Louis (II) ...
Mrs. Elizabeth ...
X
88
George G. ...
X

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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Mich

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.