

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-023523
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1799

AMENDED

ED JUL 12 1961

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|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St Louis 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 Richmond Heights | | Length of stay in 1b 4 days | | c. CITY OR TOWN St Louis Mo | |
| c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION St Mary's Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 6770 Dolan Place | |
| | | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|----------------------------------|--|--|--|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last Annie E. McKeone | | | 4. DATE OF DEATH Month Day Year 6 26 61 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11-16-80 | 9. AGE (last birthday) 80 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (City and state or country) St Louis Mo | |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Thomas Dockery | | 13b. MOTHER'S MAIDEN NAME Elizabeth Gaffney | |
| 14. NAME OF HUSBAND OR WIFE William F. McKeone | | 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. | |
| 17. INFORMANT Wm. G. McKeone | | Address 3862 Kingsland Ct | | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction | | | INTERVAL BETWEEN ONSET AND DEATH 4 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | 4201H |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Acute Leukemia | | 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 | |
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| 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"/> | 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 1956 to 6-26-61 and last saw her alive on 6-25-61
Death occurred at 3:00 am on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) Clemens J. Cullen, M.D. | 22b. ADDRESS 4161 Lennox St. St. Louis, Mo. | 22c. DATE SIGNED 6-27-61 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE 6-29-1961 | 23c. NAME OF CEMETERY OR CREMATORY Calvary |
| 23d. LOCATION (City, town, or county) St Louis Mo | 23e. DATE RECD. BY LOCAL REG. 6-28-61 | |

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| 24. FUNERAL DIRECTOR Arthur J. Donnelly | Address 3840 Lindell Blvd | 26. REGISTRAR'S SIGNATURE John C. Murphy Mrs. |
|---|-------------------------------------|---|

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

Dr C. Sullivan

4161 Lindell Blvd

01 2-1917

190
[Handwritten signature]

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 *[Handwritten Signature]*

Licensed Embalmer No. 4699

P. O. Address 3840 Lindell

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.