

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-038805

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9510 STATE FILE NUMBER

FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis -</u>		Length of stay in 1b <u>12 weeks.</u>	c. CITY OR TOWN <u>East St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>#1753 N. 46th Street.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>J.</u> Last <u>Keeley.</u>	4. DATE OF DEATH Month <u>October</u> Day <u>13th</u> Year <u>1961</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/28/1897</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Keeley Cont. Co.,</u>	11. BIRTHPLACE (City and state or country) <u>Ireland.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>
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13a. FATHER'S NAME <u>Patrick Keeley.....</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Geraghty...</u>	14. NAME OF HUSBAND OR WIFE <u>Catherine Sullivan</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes. W.W.#1</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Mrs. Catherine Keeley</u> Address <u>1753 N. 46th Street</u>
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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) <u>Central Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
DUE TO (b) _____		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hepatic cirrhosis with bleeding varices</u>		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	
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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.)
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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 _____
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21. I attended the deceased from <u>10-21-59</u> to <u>10-13-61</u> and last saw him alive on <u>10-13-61</u> Death occurred at <u>Oct. 13th 1:30 Pm</u> 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) <u>M. Homer Orzel M.D.</u>	22b. ADDRESS <u>100 N. Euclid</u>	22c. DATE SIGNED <u>10/14/61</u>
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23a. BURIAL CREMATION <input checked="" type="checkbox"/> REMOVED <input type="checkbox"/>	23b. DATE <u>Oct. 16th 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemty.</u>	23d. LOCATION (City, town, or county) <u>Belleville Ill.</u>
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24. FUNERAL DIRECTOR <u>George J. Brichler</u> ADDRESS <u>8. St. Louis</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 14 1961</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>
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DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Not Embalmed
Signed *George W. Buchlein Jr.*
By Eugene T. Campbell
Licensed Embalmer No. _____

P. O. Address _____

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.