

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-028826

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7199

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b 91/2 Years
 c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Masonic Home Hospital Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 2127 Aberdeen Pl. Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
Maud NMI Keiffer July 20 1962

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 6/24/74 9. AGE (last birthday) 88
 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) Housewife 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (City and state or country) Farmington, Mo. 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME J. Wesley Johnson 13b. MOTHER'S MAIDEN NAME Mollie O'Neall 14. NAME OF HUSBAND OR WIFE Samuel J. Keiffer

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 Masonic Home of Mo Address Sup't.

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 Thrombosis INTERVAL BETWEEN ONSET AND DEATH 10 min.
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary Atherosclerosis 4201 unknown
 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 Dec. 1955 to 7/20/62 and last saw her/him alive on 7/20/62
 Death occurred at 9:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Harold E. Walters 22b. ADDRESS 3720 Washington St. Louis, Mo. 63222 22c. DATE SIGNED Mo. 23 1962

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 7/23/62 23c. NAME OF CEMETERY OR CREMATORY Bellefontaine 23d. LOCATION (City, town, or county) St. Louis, Mo. (State) _____

24. FUNERAL DIRECTOR John L. Ziegenhein & Sons ADDRESS 7027 Gravois 25. DATE RECD. BY LOCAL REG. JUL 23 1962 26. REGISTRAR'S SIGNATURE Loan Smith. M.D.

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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ

DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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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 Donald Biny

Licensed Embalmer No. 9863

P. O. Address St. Louis, Mo.

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.