

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-033186  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2206

VS 300  
Rev. 4/59

4005  
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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

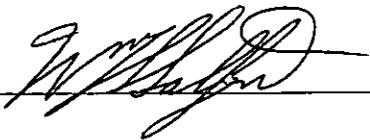
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Length of stay in lb <u>4</u> Weeks	c. CITY OR TOWN <u>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>St. Mary's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4540 Lindell Blvd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rev. Joseph G. KEATING</u>			4. DATE OF DEATH Month Day Year <u>July 28, 1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-08</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Catholic Priest</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>Danial J. Keating</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Gorman</u>	
14. NAME OF HUSBAND OR WIFE <u>--</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Walter Cuniff, 8151/2 Edna St.</u>	
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>Cerebral Thrombosis + cog. Aurb</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>-</u> 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			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
19. WAS AUTOPSY PERFORMED? YES <input 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 <u>5/4/61</u> to <u>7/27/62</u> and last saw him alive on <u>7/27/62</u> Death occurred at <u>6:00 AM - 7/28/62</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Malcolm B. Bauer M.D.</u>		22b. ADDRESS <u>4660 Maryland</u>	
22c. DATE SIGNED <u>7/28/62</u>		22d. ADDRESS (City, town, or county) (State) <u>St. Louis, Missouri</u>	
23a. BURIAL, CREMATION, REMOVAL <u>REMOVAL</u>	23b. DATE <u>July 31, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
24. FUNERAL DIRECTOR <u>John E. Murphy M.D.</u>		25. DATE RECD. BY LOCAL REG. <u>7-30-62</u>	26. REGISTRAR'S SIGNATURE <u>John E. Murphy M.D.</u>

Dr. Bawell  
4660 Maryland  
9-1245

**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  \_\_\_\_\_

Licensed Embalmer No. 46199  
P. O. Address 3846 Maryland

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.