

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10460** STATE FILE NUMBER **63-041651**  
**FILED OCT 24 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY -----		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. ----- b. COUNTY ----- <i>Linn</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>1 mo.</b>	c. CITY OR TOWN <b>Meadville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Masonic Home of Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ----- Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Ross Keith</b>			4. DATE OF DEATH Month Day Year <b>October 19, 1963</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/21/1889</b>
9. AGE (last birthday) <b>73</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY -----
11. BIRTHPLACE (City and state or country) <b>Onaga, Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John L. Keith</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Alice Deem</b>	
14. NAME OF HUSBAND OR WIFE <b>none</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Address <b>Masonic Home of Mo. 5351 Delmar Blvd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia (Terminal)</b> DUE TO (b) <b>Cerebral hemorrhage</b> DUE TO (c) <b>331x</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>8 days</b>
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 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 <b>9/12/63</b> , to <b>10/19/63</b> and last saw <sup>her</sup> him alive on <b>10/19/63</b> Death occurred at <b>7:20 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Harold E. Walters MD</b>		22b. ADDRESS <b>3720 Washington St., Meadville, Mo.</b>	
22c. DATE SIGNED <b>10-20-63</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>10/22/1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadville Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Meadville Mo.</b>		23e. STATE <b>Mo.</b>	
24. FUNERAL DIRECTOR <b>Robert Wright</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 21 1963</b>	
ADDRESS <b>Meadville, Mo.</b>		26. REGISTRAR'S SIGNATURE <b>Loed Smith, M.D.</b>	

USE BLACK INK OR TYPEWRITER RIBBON

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OCT 28 1963

**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 J. Allen Davis Jr.

Licensed Embalmer No. 4053

P. O. Address St. L.

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.