

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-046433**  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3327

DO NOT WRITE ON THIS STUB  
AMENDED

FILED DEC 6 1963

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS-CLAYTON</u> Length of stay in 1b <u>LIFE</u>		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. L. COUNTY HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6170 Minerva</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOY</u> Middle <u>M.</u> Last <u>KEEN</u>		4. DATE OF DEATH Month <u>October</u> Day <u>26</u> Year <u>1963</u>	
5. SEX <u>FEMALE</u>	6. COLOR OF RACE <u>NEGRO</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>10/28/41</u>
9. AGE (last birthday) <u>21</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>28</u>	IF UNDER 24 HR Hours <u>28</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receptionist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Peoples Hospital</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>MARVIN R. KEEN</u>	
13b. MOTHER'S MAIDEN NAME <u>MARIETTA SEALS</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</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>Marietta Keen, 6170 Minerva</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>Hodgkins disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>201X</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 checked="" 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 <u>9-20-63</u> to <u>10-26-63</u> and last saw her alive on <u>10-26-63</u> Death occurred at <u>4:00</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John M. Jarman, M.D.</u> (Degree or title)		22b. ADDRESS <u>6015 So. Brentwood-Clayton</u>	
22c. DATE SIGNED <u>10-28-63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>	
23b. DATE <u>10/31/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cemetery, St. Louis County, Mo.</u>	
23d. LOCATION (City, town, or county) (State) _____		24. FUNERAL DIRECTOR <u>Charles J. Gates, Jr., 4107 Finney</u>	
25. DATE RECD. BY LOCAL REG. <u>10-30-63</u>		26. REGISTRAR'S SIGNATURE <u>John M. Jarman, M.D.</u>	

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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 Chipton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.

*[Handwritten scribble]*