

FILED OCT 22 1943  
Registration District No. 218

Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD.

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town SAINT LOUIS:  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4959 HORTENCE PLC. /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME ANNA M. MCKEEN

3. (b) If veteran, name war NO. 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife BENJAMIN MCKEEN 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased OCTOBER 18 - 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
- 75 11 25 hr. \_\_\_\_\_ min.

9. Birthplace TERRE HAUTE INDIANA /  
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name JOSEPH STRONG  
13. Birthplace U.S.A. /  
(City, town, or county) (State or foreign country)

14. Maiden name MARY BLAKE

15. Birthplace U.S.A. /  
(City, town, or county) (State or foreign country)

16. (a) Informant MARY MCKEEN NIEDRINGHAUS

(b) Address 4931 LINDELL BLVD.

17. (a) BURIAL (b) Date thereof OCT 15/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BELLEFONTAINE CEM.

18. (a) Signature of funeral director C.R. LUPTON & SONS.

(b) Address 7233 DELMAR BLVD.

19. (a) OCT 15 1943 (b) J. J. Bullock  
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI: (b) County 000  
(c) City or town SAINT LOUIS: 17  
(If outside city or town limits, write "RURAL") 912  
(d) Street No. 4959 HORTENCE PIC:  
(If rural, give location)  
(e) Citizen of foreign country? NO. (Yes or No) 0  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10/13/43  
year \_\_\_\_\_ hour 7 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 1934 to 10/13/43 and that I last saw him alive on 10/10/43

Immediate cause of death Coronary occlusion  
Arteriosclerosis  
Heart disease 9 yrs  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Detected depression 15 yrs  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury 0

23. Signature OT Falk (M. D. or other) 200  
Address 14th Street 2nd, St. Louis Date signed 10/15/43

Duration 1 day  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

Dr. D. I. F. Green  
3604 Washington  
S.E. 1800  
Hrs. 2 - 4 P.M.

9072

9072

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Bradford A. Miles

License Embalmer No. 2901

P. O. Address University City 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 this body is not embalmed, fact should be so stated above.