V. S. No. 2
OM—8-43
5-17-39
1 X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 21 1944

318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26419

Registration District No. ..... Primary Registration District No. 1003 Registrar's No. 7042

1. PLACE OF DEATH:

(a) County .....

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4730 Newcomb Place /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 35 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Mo. (b) County 17

(c) City or town St. Louis 97
(If outside city or town limits, write "RURAL")

(d) Street No. 4969 Rosalie Ave.
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME James S. McKeon

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married /

6. (b) Name of husband or wife Ellen 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Jan. (Month) 24 (Day) 1885 (Year)

8. AGE: Years 59 Months 6 Days 17 If less than one day ..... hr. ..... min.

9. Birthplace Rhode Island (City, town, or county) / (State or foreign country)

10. Usual occupation Inspector Terminal

11. Industry or business Railroad

FATHER
12. Name Micheel McKeon
13. Birthplace ..... (City, town, or county) Scotland 4 (State or foreign country)

MOTHER
14. Maiden name Annie Rooney
15. Birthplace ..... (City, town, or county) Ireland 4 (State or foreign country)

16. (a) Informant Mrs. Ellen McKeon
(b) Address 4969 Rosalie Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-44 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J Donnelly
(b) Address 3840 Lindell Blvd.

19. (a) AUG 12 1944 (Date received in registrar) (b) J. F. Bredeck (Registrar's signature)

844

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 11
year 1944 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 7/25/44, 19..., to 8/11/44, 19...;
that I last saw him alive on 8/10/44, 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Metastatic Carcinoma Neck	8 Mon.
Due to	
Due to 55	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations Biopsy Carcinoma Primary Site unknown
Of autopsy None

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

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature C. C. Drace Jr (M. D. ~~or other~~)
Address McPacific Hospital Date signed 8/12/44

(Licensed Embalmer's Statement on Reverse Side)

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. W H Van Matre

Licensed Embalmer No. 2825

P. O. Address. 4340 Lafayette

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.