

FILED MAY 6 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13898

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3750

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5724 Delor St.		d. STREET ADDRESS (If rural, give location) 5724 Delor St.	
3. NAME OF DECEASED a. (First) James (Type or Print) b. (Middle) L. c. (Last) O'Keefe			4. DATE OF DEATH (Month) (Day) (Year) April 23 1954
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 17, 1882
9. AGE (In years last birthday) 72		10. KIND OF BUSINESS OR INDUSTRY Delivery Forman	11. BIRTHPLACE (City and State or Foreign Country) St. Louis
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME John O'Keefe		13b. MOTHER'S MAIDEN NAME Mary Jane Richardson	14. NAME OF HUSBAND OR WIFE Lillian O'Keefe
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 488-05-5563	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lillian O'Keefe 5724 Delor St.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Occlusion DUE TO (c) Coronary Sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4201	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:51 p.m., from the causes and on the date stated above.			
23a. SIGNATURE Patrick P. Taylor Coronet		23b. ADDRESS 1300 Clark	23c. DATE SIGNED 4-26-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Apr. 27 1954	24c. NAME OF CEMETERY OR CREMATORY Calvary Cem	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
DATE REC'D BY LOCAL REG. APR 26 1954	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Gabken Sons 2630 Gravois	

(Licensed Embalmer's Statement on Reverse Side)

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

**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 .....  
Student Embalmer

Signed Robert F. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois

**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.