

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-013563

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3712 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

FILED APR 8 1963

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Missouri | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Lincoln | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 30 min. | c. CITY OR TOWN Winfield |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardinal Glennon Memorial Hospital for Children | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Rt. 1 |
| 3. NAME OF DECEASED (Type or print) First Middle Last Debra Jean McKeage | | 4. DATE OF DEATH Month Day Year March 31 1963 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11-7-59 |
| 9. AGE (last birthday) 3 yrs | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Missouri |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME Robert D. Mc Keage | |
| 13b. MOTHER'S MAIDEN NAME Barbara (Lewis) | | 14. NAME OF HUSBAND OR WIFE Single | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCE (Yes, no, or unknown) (If yes, give war or dates) No | | 17. INFORMANT Address Robert D. Mc Keage Rt. 1 Winfield Mo. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) labar pneumonia DUE TO (b) in severely brain damaged (congenital) female child DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 490x | | | INTERVAL BETWEEN ONSET AND DEATH 48 hours 3 1/2 years |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) 490x | | | |
| 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 10-3-60 to 3-31-63 and last saw her live on 3-31-63 Death occurred at 12 noon on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) W. J. Davis M.D. | | 22b. ADDRESS 150 N. Main | |
| 22c. DATE SIGNED 4-1-63 | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | |
| 23b. DATE 4/2/63 | | 23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery | |
| 23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. | | 24. FUNERAL DIRECTOR Collier Mortuary, St. Ann, Mo. | |
| 25. DATE RECD. BY LOCAL REG. APR 1 1963 | | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | |

USE BLACK INK OR TYPEWRITER RIBBON

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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

Sheldon Collier

Licensed Embalmer No.

3382

P. O. Address

St. Ann 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.