

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39950

State File No. _____

FILED DEC 7 1953

BIRTH NO. _____		REG. DIST. NO. <u>278</u>		PRIMARY REG. DIST. NO. <u>3054</u>		Registrar's No. <u>443</u>	
1. PLACE OF DEATH a. COUNTY <u>Pike</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Louisiana</u>			c. LENGTH OF STAY (In this place) <u>1 1/2 months</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Louisiana</u>			<u>0921</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pike Co. Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>617 Nebraska St.</u>			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM</u>		a. (First)		b. (Middle) <u>FRANCIS</u>		c. (Last) <u>KEYS</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>NOV. 16, 1953</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	
8. DATE OF BIRTH <u>Oct. 18, 1940</u>		9. AGE (In years last birthday) <u>13</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>28</u>		IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>0</u> <u>St. Louis Co., Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13a. FATHER'S NAME <u>WILLIAM FRANCIS KEYS</u>		13b. MOTHER'S MAIDEN NAME <u>BERTHA McCLARIE</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. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>William Francis Keys Sr., Louisiana, Mo.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Hemorrhagic Nephritis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Glomerular Nephritis 2 yrs</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Acute Secondary Anemia from Hemorrhage</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>592X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)			
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 <u>Sept. 1953</u> , to <u>Nov. 16, 1953</u> , that I last saw the deceased alive on <u>Nov. 16, 1953</u> and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>ROBERT L. ANDRAE, M.D.</u> <u>Robert L. Andrae M.D.</u>				23b. ADDRESS <u>216 Georgia St. Louisiana, Mo.</u>		23c. DATE SIGNED <u>11-18-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>11/18/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Louisiana, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Nov. 24, 1953</u>		REGISTRAR'S SIGNATURE <u>Bernese Collier</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>378</u>		ADDRESS <u>Sterne Funeral Home, Louisiana, Mo.</u>	

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

DEC 14 1958

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 Virginia M. Stern

Licensed Embalmer No. 4645

P. O. Address Louisiana, 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.