

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

28748

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. City Infirmary) St. _____ Ward _____

File No. _____
 Registered No. 8289

2. FULL NAME

Frank Keller
 (a) Residence. No. City Infirmary St. 13 Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred life yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male | **4. COLOR OR RACE** White | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single
 (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 11th 1868

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>59</u>	<u>8</u>	<u>5</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Teamster
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Jacob Keller

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Susie Young

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

14. INFORMANT Mrs. Effinger
 (Address) City Infirmary

15. FILED 17. 1927 May Starnitz
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 16 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1927 to Sept 16 1927 that I last saw him alive on Sept 15 1927, and that death occurred, on the date stated above, at 2:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
108 / 1010
870 (duration) yrs. mos. 2 da.
CONTRIBUTORY (SECONDARY) Paraplegia cause
unknown (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____
19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
20. WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) W. Lanning M. D.
 , 19 (Address) City Infirmary

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Valhalla Cemetery **DATE OF BURIAL** Sept. 19, 27
20. UNDERTAKER Deiss-Willmerring ADDRESS 3203 Salisbury

WRITE PENICIL, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

