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

Do not use this space.

28952

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 8530

City St Louis (No. City Hospital St. ..... Ward)

2. FULL NAME Curtis L. Keller

(a) Residence. No. 2515 North Market St., 20 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 12-1926

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
1	3	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Roy Keller
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cuba
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Ruth Hartman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Cuba
(STATE OR COUNTRY) Mo

14. INFORMANT Roy Keller
(Address) 2515 N Market

15. FILED SEP 25 1927 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-24-1927

17. I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1927, to Sept. 24, 1927 that I last saw him alive on Sept. 24, 1927, and that death occurred, on the date stated above, at 1:50 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute enteritis and diarrhea
113B
113B
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
0 DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Edmund R. Sheridan, M. D
, 19 (Address) City Hosp.

*State the DISEASE CAUSING DEATH, or in 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: Cuba Mo.
DATE OF BURIAL: 9/26 1927

20. UNDERTAKER: Wm M Ehrmacher
ADDRESS: 1844 N Jefferson

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.