WRITE PLAINLY, 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.

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

Do not use this space.

✓ 38418

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 11086

City St Louis (No. 4359 Taft Ave St. ..... Ward)

2. FULL NAME Belle M Keckeler

(a) Residence. No. ..... St., 15 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Edwin T Keckeler

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown 1866

7. AGE: Years abt. 61 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY): Kentucky

PARENTS
10. NAME OF FATHER: Unknown Morris
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Ky.
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Ky.

14. INFORMANT: Joseph A Michal
(Address) 316 N 8th St

15. FILED DEC 12 1927, 19..... REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 10th 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 25, 1927, to Dec 10th 1927, that I last saw her alive on Dec 10, 1927, and that death occurred, on the date stated above, at 15 m. 9 A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Haemorrhage

82A

1092 ..... (duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (SECONDARY): Hypertension

..... (duration) 3 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 9 A

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Walter S Fielding M.D.

12/10, 1927 (Address) 4724 Gravois

*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: Calvary
DATE OF BURIAL: 12-13 1927

20. UNDERTAKER: Arthur J Donnelly
ADDRESS: 2039 Wash St

4724

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 ..... Registered No. 11086

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

2. FULL NAME Belle M Keckler

(a) Residence. No. ..... St., ... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED JAN 19 1928 Max C Starkcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 10 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

...B.—Every item of inform... should be carefully supp...
CAUSE OF DEATH in plain terms, so that it may be properly clas...
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-38418