

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

Do not use this space.

20703  
20703  
5495  
24

1. PLACE OF DEATH

County.....  
Township.....  
City..... *St. Louis* (No.....)

Registration District No. *791*

Primary Registration District No. *1003*

File No.....  
Registered No. *5495*  
St. *24* (Ward)

**ISOLATION HOSPITAL**

2. FULL NAME

*Beatrice Keller*

(a) Residence No. *3816 Olive* St. *19* 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)

*Single*

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

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

*June 25, 1926*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

*3*

*11*

*10*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

*nil*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

*St. Louis, Mo.*

(STATE OR COUNTRY)

10. NAME OF FATHER

*Harry Keller*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

*Penn*

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

*Marie Max*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

*Ohio*

(STATE OR COUNTRY)

14. INFORMANT

*e. Sheridan*  
(Address) *ISOLATION HOSPITAL*

15. FILED

*May 6 1936*  
*May C. Stanley*  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

*June 5 1930*

17.

I HEREBY CERTIFY, That I attended deceased from *June 1*, 19*30* to *June 5*, 19*30* that I last saw her alive on *June 5*, 19*30*, and that death occurred, on the date stated above, at *10:40 A.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*diphtheria, laryngeal*  
*10/11511*

(duration) yrs. mos. *19* ds.

CONTRIBUTORY (SECONDARY)

*Secondary streptococci*  
*epitaxial throat* (duration) yrs. mos. *7* 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) *W. C. Kellid*, M. D.

*6-5-1930 ISOLATION HOSPITAL*

\*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

*Calvary*

*6-6-1930*

20. UNDERTAKER

ADDRESS

*Arthur J. Donnelly 2039 Wash St*

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.

