

FILED APR 14 1943

Registration District No. **42**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County **Buchanan**  
(b) City or town **St. Joseph**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Missouri Methodist Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **3 months**  
(Specify whether  
In this community **69 years**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**  
(c) City or town **St. Joseph**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1416 Main Street**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **1**

3. (a) PRINT FULL NAME **Laura Elizabeth Keller**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **Widow**  
6. (b) Name of husband or wife **William T. Keller** 6. (c) Age of husband or wife if alive **years**  
7. Birth date of deceased **September 18 1854**  
(Month) (Day) (Year)

8. AGE: Years **88** Months **5** Days **29** If less than one day hr. min.

9. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER  
{ 12. Name **Unknown Barth**  
13. Birthplace **Unknown Germany 4**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Phillipina Robyn**  
15. Birthplace **Unknown Germany 4**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Wm. B. Keller**  
(b) Address **1416 Main St. St. Joseph, MO.**

17. (a) **Burial** (b) Date thereof **3-20-1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ashland Cemetery**

18. (a) Signature of funeral director **Walter Meierhoffer**  
(b) Address **13th. & Farnon St. St. Joseph, Mo.**

19. (a) **3-20-43** (b) **Alce Herzog**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **17th.**  
year **1943** hour **12:35** minute **P.** M.

21. I hereby certify that I attended the deceased from **Dec. 6-42** to **March 17, 1943**  
that I last saw her alive on **March 17, 1943**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Fractured Hip Hip Dec 6-42**  
Duration

Due to **arteriosclerosis**  
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **131**   
(b) Date of occurrence **7**  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **L. O. Bauman** (M. D. or not) **D**  
Address **Kelpatriek City** Date signed **3/19/43**

1255 (Licensed Embalmer's Statement on Reverse Side) **J. J. Jones Mo**

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

MOTHER FATHER

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**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~~.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Geo E Daniel

Licensed Embalmer No. 3300 Missouri

P. O. Address St. Joseph, Missouri

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 9632  
Registrar's No. 365

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME Laura E. Keller

3. (b) If veteran, name war No. 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 88 Months 5 Days no. (If less than one day min.)

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County  
(c) City or town (If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH year 1943 hour minute M.

21. I hereby certify that I attended the deceased from that I saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death fracture left femur - 6-82 Duration

Due to arteriosclerosis

Due to Decubitus - extensive

Other conditions (Include pregnancy within 5 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Dec 11 - 43

(c) Where did injury occur? St. Joseph Buchanan Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? her home - 11 PM

While at work? (Specify type of place) (e) Means of injury fall

23. Signature R. C. Bauman (M. D. or other)

Address St. Joseph Mo Date signed 4/26/43

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

SUPPLEMENTARY

MOTHER FATHER

