DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 3 1944

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 1507

Registrar's No. 138

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days (Specify whether

In this community 10 da years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte 977

(c) City or town Kansas City 14
(If outside city or town limits, write "RURAL") 0

(d) Street No. 1820 Dodd Box 239 RR#5
(If rural, give location)

(e) Citizen of foreign country? Yes. (Yes or No)

If yes, name country 2

3. (a) PRINT FULL NAME Robert C. Keller

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race Wh 0

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Anna Keller

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased December 15, 1865 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
78	0	24	hr. min.

9. Birthplace Saxon (City, town, or county) Germany 4 (State or foreign country)

10. Usual occupation Tailor

11. Industry or business Self

FATHER
12. Name Carl Keller
13. Birthplace No Record (City, town, or county) Germany 4 (State or foreign country)

MOTHER
14. Maiden name Amelia Horscher
15. Birthplace No Record (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant Miss Melitta Keller

(b) Address 1820 Dodd K.C.Kans.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/44 (Month) (Day) (Year)

(c) Place: burial or cremation calvary Cemetery

18. (a) Signature of funeral director Gates Funeral Home

(b) Address 1901 Olathe Blvd. K.C.Kans.

19. (a) Jan 11, 1944 (Date received local registrar) (b) F E Brown (Registrar's signature)

361

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 9th year 1944 hour 3 minute 30 A M.

21. I hereby certify that I attended the deceased from 11/19/48, 19..., to 1/9/44, 19...; that I last saw him alive on 1/8/44, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chr. Myocarditis	?
Due to 93d	
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)

(b) Date of occurrence

(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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature [signature] (M. D. or other)

Address 1421 S. M. Blvd. K.C.K. Date signed 1/10/44

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....3991

P. O. Address.....309 E. 67th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.