V. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 12 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11409

Registration District No. 1318 Primary Registration District No. 1003 Registrar's No. 3789

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

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days (Specify whether years, months or days)
In this community 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town ST LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 5639 LANSDOWNE AV
(If rural, give location)
(e) Citizen of foreign country? O (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME HARVEY KELLAR
3. (b) If veteran, name war ✓
3. (c) Social Security No. 489-10-8814
4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of ~~husband or~~ wife MAMIE KELLAR
6. (c) Age of husband ~~or wife~~ if alive 55 years
7. Birth date of deceased JULY (Month) 14 (Day) 1875 (Year)
8. AGE: Years 69 Months ~~8~~ Days 14 If less than one day hr. min.
9. Birthplace BALLS Co. (City, town, or county) MO. (State or foreign country)
10. Usual occupation MACHINEST
11. Industry or business
FATHER 12. Name PHILLIP KELLAR
FATHER 13. Birthplace (City, town, or county) GERMANY (State or foreign country)
MOTHER 14. Maiden name CAROLINE WEST
MOTHER 15. Birthplace UNKOWN (City, town, or county) (State or foreign country)
16. (a) Informant MRS MAMIE KELLAR
(b) Address 5639 LANSDOWNE AV.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-45 (Month) (Day) (Year)
(c) Place: burial or cremation Hannibal, Mo
18. (a) Signature of funeral director Schwartz Funeral Home
(b) Address Hannibal Mo
19. (a) APR 29 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28th year 1945 hour 12:15 minute A. M.
21. I hereby certify that I attended the deceased from 4/19/45, 19..., to 4/28/45, 19...; that I last saw him alive on 4/28/45, 19...; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Cerebral Hemorrhage
Due to
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?
While at work? (Specify type of place) (e) Means of injury
23. Signature James J. Smith (M. D. or other)
Address 1515 Lafayette Date signed 4/28/45

(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 John Ketter

Licensed Embalmer No. 3880

P. O. Address St Louis Mo.

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.