

FILED NOV 29 1945  
318

Primary Registration District No.

1003

1. PLACE OF DEATH:

(a) County St Louis MO  
(b) City or town St Louis MO  
(c) Name of hospital or institution: Miss. River Inst. of General  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County \_\_\_\_\_  
(c) City or town St Louis  
(d) Street No. Clark  
(e) Citizen of foreign country? \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

LOUIS KELLETT (LOUIS PETERS)

20. DATE OF DEATH

Month Oct day 16 year 1945 hour \_\_\_\_\_ minute 30 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Wife 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

Immediate cause of death Asphyxiation due to drowning  
Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ 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 \_\_\_\_\_

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

16. (a) Informant Tom J. Colquhoun

(b) Address 1300 Clark

17. (a) BURIAL (b) Date thereof 11-23-45  
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington

19. (a) NOV 23 1945 (b) J. F. Bedeck  
(Date received by registrar) (Registrar's signature)

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) \_\_\_\_\_  
Means of injury \_\_\_\_\_

23. Signature John E. Taylor (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

**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.

*No Embalmed*

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10116

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

**1. PLACE OF DEATH:**

(a) County.....  
 (b) City or town St Louis  
(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 Unknown

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive 1880 years

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

8. AGE: Years Months Days If less than one day

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.....

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) (Data 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 Dec Day 16 Year 1945 hour..... minute 30 M.

21. I hereby certify that I attended the deceased from..... to....., 19.....  
 that I last saw him..... alive on....., 19.....  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations.....

Of autopsy.....

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

(a) Accident, suicide, or homicide (specify) Open Verdict

(b) Date of occurrence Oct 16 1945

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Mississippi River  
(Specify type of place) (e) Means of injury As above

23. Signature St Louis & Taylor (M.D. or other)

Address St Louis Date signed 12/17/45

**SUPPLEMENTARY**

**ADDITIONAL  
 SUPPLEMENTARY  
 INFORMATION  
 REQUESTED**

**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

23 d

31056

**FILED** APR 4 1945 **STANDARD CERTIFICATE OF DEATH** State File No. \_\_\_\_\_  
Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10116**

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution: Miss River Foot of Arsenal  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Louis Kellette (Louis Peters)  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: 12 - 12 - 1893  
(Month) (Day) (Year)

8. AGE: Years 89 Months 2 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name Joseph Peters  
13. Birthplace Germany (City, town, or county) (State or foreign country)  
14. Maiden name Katharina Kellette  
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Alice Peters (Niece)  
(b) Address 437 Belmont (Creston)  
17. (a) Burial (b) Date thereof 3-29-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Old St. Peter + Paul  
18. (a) Signature of funeral director Parker Wood  
(b) Address Webster Groves, Mo.  
19. (a) 11-29-45 (b) J. F. Brueck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis 10  
(d) Street No. 3815 Lee Ave  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years

MEDICAL CERTIFICATION:  
20. DATE OF DEATH: Month October day 16 1945 hour 8 minute 30 a.m.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxiation due to drowning in her front yard in the Mississippi River near the foot of Arsenal Street on Oct 16 1945 about 1:30 P.M.  
Due to Force Blows Cause and manner of same could not be determined  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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) Pen Verdict  
(b) Date of occurrence Oct 16 1945  
(c) Where did injury occur? St. Louis Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Mississippi River  
White at work? \_\_\_\_\_ (Specify type of place) (a) Means of injury 6 ft bar  
23. Signature John E. Taylor (M. D. or other) \_\_\_\_\_  
Address Dep. Co. Date signed \_\_\_\_\_

Mrs. Madge P. Kennedy  
Director of Vital Statistics  
State Board of Health  
Jefferson City, Missouri

Dear Mrs. Kennedy:

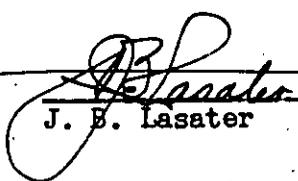
Enclosed find substitute death certificate on Louis Kelleter, who died October 16, 1945 and was buried in City Cemetery November, 1945, as an unidentified person.

Identification has now been made by his niece. The body has been disinterred from the City Cemetery and re-buried in Old St. Peter and Paul Cemetery.

Please replace the certificate on file in your office with the enclosed.

Yours very truly,

BUREAU OF VITAL STATISTICS

  
J. E. Lasater

36056  
..... Registered Apprentice No.....

.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.