

FILED MAR 24 1947

Registration District No. **318** Primary Registration District No. **1003**

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:
WOMEN DEPENDENT HOSPITAL
(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 IGNAZ KELLER

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

4. Sex MALE 5. Color or race WHITE 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 NOVEMBER 14 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 3 25 hr. min.

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

10. Usual occupation CLERK

11. Industry or business BUTLER BRO.

12. Name ANTON KELLER

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

14. Maiden name KATHERIN

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

16. (a) Informant JOSEPHINE E. FLANCK

(b) Address 7092 WINONA AVE

17. (a) CREMATION (b) Date thereof 3-13-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation VALHALLA CEMETERY

18. (a) Signature of funeral director M. J. CLOGHAN
(b) Address 7146 MANCHESTER AVE

19. (a) MAR 12 1947 (b) J. F. Bredesch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County.....
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 4251 CHATEAU AVE
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 11
year 1947 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan 4 1942
to 3-11-47, 19....., to 3-11-47, 19.....

That I last saw her alive on 3-11-47, 19....., and that death occurred on the date and hour stated above.

Immediate cause of death Cardio nephritis
Due to severe

Other conditions 1/2/1
(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).....

(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 J. F. Cappel (M.D. or other).....

Address 3284 Lombard Ave Date signed 3-17-47

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Albert J. Hoppe

Licensed Embalmer No. 2971

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.