

No. 300  
-10-47  
5-17-39  
I 3906

FILED SEP 7 1948  
Registration District No. **317**

Primary Registration District No. **6076**

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Halls Ferry Memorial Home  
(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 Ida H. Keller

3: (b) If veteran, name war No

3: (c) Social Security No. 334-12-3125A

4. Sex Female 5. Color or race White

6: (a) Single, widowed, married, divorced Widow

6: (b) Name of husband or wife George Keller

6: (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 27 1870  
(Month) (Day) (Year)

8. AGE: Years 78 Months 1 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Robert Hodges

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

14. Maiden name Nancy Unknown

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

16: (a) Informant Edith Williamson

(b) Address Route 1, Box 452, Clayton, Mo.

17: (a) Removal (b) Date thereof 8-23-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jacksonville, Ill.

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

(b) Address 4700 Washington Blvd.

19: (a) AUG 24 1948 (b) Cecil H. Magee M.D.  
(Date received local registrar) (Registrar's signature) (S.H.)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Clayton  
(If outside city or town limits, write "RURAL")

(d) Street No. Route 1, Box 452  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 22 year 1948 hour 2 minute 45 P.M.

21. I hereby certify that I attended the deceased from April 1948 to Aug 22 1948

that I last saw h. alive on Aug 22 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration \_\_\_\_\_

Due to Arteriosclerosis

Due to — 83h

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 M. S. Spawer (M. D. or other) \_\_\_\_\_

Address Furdell Bank Bldg Date signed 8-23-48

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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 Frank J. Hyland  
Licensed Embalmer No. 29645  
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.**