

FILED AUG 13 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24985  
6826  
State File No. ....  
Registrar's No. ....

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1008</b>	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN <u>St. Louis</u> )		c. LENGTH OF STAY (in this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Lukes Hosp.</u>
3. NAME OF DECEASED (Type or Print) a. (First) <u>Rose</u> b. (Middle) <u>Haentges</u> c. (Last) <u>Keller</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 4 1949</u>		5. SEX <u>Female</u>
6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Mar. 27 1868</u>		9. AGE (In years last birthday) <u>81</u> UNDER: YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? _____
13a. FATHER'S NAME <u>William Welker</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Charles S. Keller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Charles S. Keller 2912 Salena St.</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis general</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>5 years</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>99.</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>HSD</u>			
22. I hereby certify that I attended the deceased from <u>May 1945</u> , to <u>Aug. 4, 1949</u> , that I last saw the deceased alive on <u>Aug 4, 1949</u> , and that death occurred at <u>8:00 p. m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Name or title) <u>W. Heiden</u>		23b. ADDRESS <u>508 N. Grand</u>		23c. DATE SIGNED <u>8-5-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-8-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>	
DATE RECD BY LOCAL HEALTH DEPT. <u>AUG 5 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Pasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Witt Bros &amp; Blum 29 S. Jefferson</u>	

WRITE PLAINLY—USING 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 \_\_\_\_\_

*Davis*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *E. F. Witt*  
Licensed Embalmer No. *2117*

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.