

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **38913**
9267

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____																					
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Missouri				b. COUNTY St. Louis																			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis				c. LENGTH OF STAY (in this place)				c. CITY OR TOWN Webster Groves				d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>															
d. FULL NAME OF HOSPITAL OR INSTITUTION 4348 Osceola Street				e. STREET ADDRESS (If rural, give location) 157 S. Laclede Station Road																							
3. NAME OF DECEASED (Type or Print)				a. (First) MARY				b. (Middle) K.				c. (Last) KELLER				4. DATE OF DEATH (Month) (Day) (Year) Oct. 12, 1954											
5. SEX Female				6. COLOR OR RACE White				7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow				8. DATE OF BIRTH March 12, 1869				9. AGE (in years last birthday) 85 yrs.				10. IF UNDER 1 YEAR Months Days				10. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY household				11. BIRTHPLACE (City and State or Foreign Country) <input checked="" type="checkbox"/> St. Louis, Missouri				12. CITIZEN OF WHAT COUNTRY? USA															
13a. FATHER'S NAME Aloys Vogler				13b. MOTHER'S MAIDEN NAME Katherine Wendel				14. NAME OF HUSBAND OR WIFE Oscar A. Keller																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -				17. INFORMANT'S SIGNATURE OR NAME Edwin O. Keller, 4348 Osceola Street				ADDRESS															
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Schistosomiasis DUE TO (c) Hepatitis Chr. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Obesity								INTERVAL BETWEEN ONSET AND DEATH 2 10 yr 10 yr															
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) 442 X																			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?																			
22. I hereby certify that I attended the deceased from Jan 5, 1949 , to Oct 11, 1954 , that I last saw the deceased alive on Oct 11, 1954 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above.																											
23a. SIGNATURE Carl G. Smith MD				(Degree or title)				23b. ADDRESS 227 E. Lockwood				23c. DATE SIGNED 10-12-54															
24a. BURIAL, CREMATION, REMOVAL (Specify)				24b. DATE 10-14-54				24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery				24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri															
DATE REC'D BY LOCAL REG. OCT 13 1954				REGISTRAR'S SIGNATURE J. Carl Smith MD				25. FUNERAL DIRECTOR'S SIGNATURE Beiderwieden F.H. Inc.				ADDRESS 1936 St. Louis Ave.															

(Licensed Embalmer's Statement on Reverse Side)

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 _____, Student Embalmer No. None working under my personal supervision..

Student None
Signature of Student Embalmer

Signed Delis J. Kispin

Licensed Embalmer No. 349

P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.