

FILED DEC 16 1954

STANDARD CERTIFICATE OF DEATH

42517
State File No. 10718

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10718**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
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 St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital		f. STREET ADDRESS (If rural, give location) 2099 9 2019 Obear	

3. NAME OF DECEASED (Type or Print) a. (First) HULDA L. KEITZ b. (Middle) c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) November 24th, 1954	
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced	8. DATE OF BIRTH October 20th 1897	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months Days	IF UNDER 1 HR. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Co., Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Fred Neustadt	13b. MOTHER'S MAIDEN NAME Anna Bierkenkamp	14. NAME OF HUSBAND OR WIFE William Keitz
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 497-20-9540	17. INFORMANT'S SIGNATURE OR NAME Isabelle Muckle, 251 Coburg	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 19 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident		
	ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? 331X
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22. I hereby certify that I attended the deceased from **11-5, 1954**, to **11-24, 1954**, that I last saw the deceased alive on **11-23, 1954**, and that death occurred at **6:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E.H. Kieker, MD	23b. ADDRESS 3121 N. Grand	23c. DATE SIGNED 11-24-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 11/27/54	24c. NAME OF CEMETERY OR CREMATORY Friedens cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. NOV 24 1954	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE DIEDRICH FUNERAL HOME, 8319 Hall's Ferry	ADDRESS
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(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..... working under my personal supervision.:

Student.....
Signature of Student Embalmer

Signed *Eleonore Remelius*.....

Licensed Embalmer No. *4283*

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.