

FILED SEP 1 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27847

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6634

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	d. RESIDENCE WITHIN LIMITS OF A CITY OR INCORPORATED TOWN? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute City Hospital		e. STREET ADDRESS 27	(If rural, give location) 2226 Olive St. <i>22170</i>

3. NAME OF DECEASED (Type or Print)	a. (First) Andrew	b. (Middle)	c. (Last) Keller	4. DATE OF DEATH (Month) (Day) (Year) July 29, 1955
-------------------------------------	----------------------	-------------	---------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH April 16, 1888	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months	IF UNDER 6 HRS. Hours	IF UNDER 15 MIN. Min.
----------------	---------------------------	---	------------------------------------	---------------------------------------	---------------------------	--------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator	10b. KIND OF BUSINESS OR INDUSTRY Book Store	11. BIRTHPLACE (City and State or Foreign Country) Austria-Hungary	12. CITIZEN OF WHAT COUNTRY? U.S.
---	---	---	--------------------------------------

13a. FATHER'S NAME Adolf Keller	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE None
------------------------------------	--------------------------------------	-------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I	16. SOCIAL SECURITY NO. 490-38-7578	17. INFORMANT'S SIGNATURE OR NAME L. Lee Foland	ADDRESS 8100 Edinburgh Dr.
--	--	--	-------------------------------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MEDICAL CERTIFICATION <i>Left Coronary Occlusion;</i>		INTERVAL BETWEEN ONSET AND DEATH.
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <i>Generalized and Coronary Artery Sclerosis;</i>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Carcinoma of Sigmoid</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <i>4201H</i>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at *10:26 A.M.* on \_\_\_\_\_, 19\_\_\_\_, from the causes and on the date stated above.

23a. SIGNATURE <i>Patrick P. Taylor</i>	23b. ADDRESS <i>1300 Clark</i>	23c. DATE SIGNED <i>8.1.55</i>
--	-----------------------------------	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE 8-2-55	24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
--	---------------------	--	---

DATE REC'D BY LOCAL REG. AUG 1 1955	REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Albert H. Hoppe</i>	ADDRESS 4700 Washington Blvd.
--	---	--	----------------------------------

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..... *Paul A. Wach*.....

Licensed Embalmer No. *470*

P. O. Address *Howe*

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.