

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**435333**  
STATE FILE NUMBER

FILED DEC 30 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1399

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1913 Jones St.,</u>		Length of stay in 1b <u>Life time</u>	d. STREET ADDRESS <u>1913 Jones St.,</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Wilma</u> Middle <u>P.</u> Last <u>Keller</u>			4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1957</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 9, 1875</u>		9. AGE (In years birthdays) <u>82</u> IF UNDER 1 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 <u>same</u>	11. BIRTHPLACE (City and state or country) <u>St. Joseph, Missouri.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>William T. Keller</u>		13b. MOTHER'S MAIDEN NAME <u>Laura Barth</u>		14. NAME OF HUSBAND OR WIFE <u>-----</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Chas. W. Anderson, Kansas City, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>					<u>Over 2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II. of item 18.) <u>4201</u>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____
21. I attended the deceased from <u>7/24/57</u> to <u>12/13/57</u> and last saw her alive on <u>12/13/57</u> Death occurred at <u>8:15</u> <u>Am</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Robert Fulton</u> (Degree or title)			22b. ADDRESS <u>218 N. 7, St. Joseph, Mo.</u>		22c. DATE SIGNED <u>12/20/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City; town, or county) (State)
<u>Burial</u>		<u>Dec. 20, 1957.</u>	<u>Ashland Cemetery</u>		<u>St. Joseph, Missouri.</u>
24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Dec. 26, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

780

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01.20

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 *Eric J. Cherry*

Licensed Embalmer No. 4679

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