

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

45998
STATE FILE NUMBER

11874
Registrar's No.

Registration District No. 318 Primary Registration District No.

S. 300
v. 1-57

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Clayton
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 6435 Clayton Rd.

3. NAME OF DECEASED (Type or print) First Middle Last ROBERT ALLEN KELLER			4. DATE OF DEATH Month Day Year DECEMBER 9, 1957		
---	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1929	9. AGE (In years (age birthday)) 27	IF UNDER 1 YEAR Month Day 11 25	IF UNDER 24 HRS. Hours Min. 0 0
-------------	------------------------	---	--------------------------------	--	---------------------------------------	---------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Health Eng.	10b. KIND OF BUSINESS OR INDUSTRY Health Dept.	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	--

13a. FATHER'S NAME Oliver Keller	13b. MOTHER'S MAIDEN NAME Elsie Sudhoff	14. NAME OF HUSBAND OR WIFE Mary Jo Cable Keller
-------------------------------------	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes Korean War	16. SOCIAL SECURITY NO. 499-28-8096	17. INFORMANT Mary Jo Cable Keller	Address 6435 Clayton Rd.
--	--	---------------------------------------	-----------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKIN'S DISEASE		INTERVAL BETWEEN ONSET AND DEATH 3 YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	201x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <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 DEC. 3, 1957 to DEC. 9, 1957 and last saw her alive on DEC. 9, 1957 Death occurred at 1:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>C. P. Vermillion, M.D.</i> (Degree or title) M. D.	22b. BARNES HOSPITAL	22c. DATE SIGNED 12/10/57
---	----------------------	------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-13-57	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
--	-----------------------	--	---

24. FUNERAL DIRECTOR Ambruster Mortuary	ADDRESS 6633 Clayton Rd.	25. DATE RECD. BY LOCAL REG. DEC 11 1957	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith mo</i> m & B.
--	-----------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 

Licensed Embalmer No. 4788

P. O. Address St. Louis, 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.