

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008183
STATE FILE NUMBER

FILED FEB 28 1958

Registration District No. 317 Primary Registration District No. 545 Registrar's No. 316

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maplewood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</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>37 Maplewood Nurs. Home 1YR</u>			Length of stay in 1b <u>1YR</u>		d. STREET ADDRESS (If outside, give location) <u>21570 4436 Delor</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Jane</u> Last <u>Keller</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>31</u> Year <u>1958</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 24, 1885</u>		9. AGE (in years last birthday) <u>73</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>Housekeeping</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Dennis Conner</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy -----</u>			14. NAME OF HUSBAND OR WIFE <u>Carl E. Keller</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>Unknown</u>		17. INFORMANT Address <u>Carl D. Keller-9034 Patrick Dr. (21)</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>Cerebral Arteriosclerosis & Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____		DUE TO (c) _____		<u>332X</u>	
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 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.)					
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 <u>Oct. 1938</u> to <u>1/31/58</u> and last saw her alive on <u>1/29/58</u> Death occurred at <u>10:20 P.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>B. U. Glassberg</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>4500 Olive St.</u>			22c. DATE SIGNED <u>2/1/58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb. 3, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>			
24. FUNERAL DIRECTOR <u>WACKER-HELDERLE-3634 Gravois Ave.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>2/3/58</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Danke M.D.</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Frank J. Hand*

Licensed Embalmer No. *2267*

P. O. Address *W. Harris*

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.