

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003831

FILED FEB 11 1959

Registration District No.

317

Primary Registration District No.

545

STATE FILE NUMBER

Registrar's No. 340

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|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Maplewood</b>                       |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>St. Louis</b> <b>2149</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                            |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>2200 Bredell Ave BYRS</b> |  | Length of stay in 1b   | d. STREET ADDRESS (If outside, give location)<br><b>5515 Neosho St</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|   |                                  |   |  |  |   |                                |
|---|----------------------------------|---|--|--|---|--------------------------------|
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY</b> Middle <b>ANN</b> Last <b>KEIL</b> |                                  |   | 4. DATE OF DEATH<br>Month <b>2</b> Day <b>2</b> Year <b>1959</b> |  |   |                                |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-29-1879</b>                             | 9. AGE (In years last birthday)<br><b>79</b> | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Hours Min. |

|   |                                   |   |   |
|---|-----------------------------------|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At Home</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis Mo 0</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
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|---|--|---|
| 13a. FATHER'S NAME<br><b>Andrew A. Kupferer</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Mack</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Christian Keil (Deceased)</b> |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Young or unknown) (If yes, give war or dates of service)<br><b>NO</b> | 16. SOCIAL SECURITY NO.<br><b>None</b> | 17. INFORMANT<br><b>Vernon C. Keil R.R. #1 Eureka Mo</b><br>Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage with left hemiplegia</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>11 weeks 5 days</b>  |                 |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <b>Hypertension, arteriosclerosis</b> |   | <b>20 years</b> |
|  | DUE TO (c) <b>Arteriosclerosis general</b>       |   | <b>20 years</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>3317</b>                                 |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 |

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|---|--|
| 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<br>Hour Month, Day, Year<br>a.m.<br>p.m.  |  |

|  |  |   |
|--|--|---|
| 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 <b>Feb 9, 1953.</b> to <b>Feb 2, 1959</b> and last saw her <sup>her</sup> alive on <b>Feb 1, 1959</b><br>Death occurred at <b>5:30 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |

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| 22a. SIGNATURE (Degree or title)<br><b>Ch Bockelman M.D.</b> | 22b. ADDRESS<br><b>2615 Brentwood Blvd</b> | 22c. DATE SIGNED<br><b>2/3/59</b>                                    |   |
| 23a. BURIAL CREMATION<br><b>Burial</b>                       | 23b. DATE<br><b>2-4-1959</b>               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Old St. Marcus Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>6638 Gravois Ave Mo</b> |

|   |                                   |   |   |
|---|-----------------------------------|---|---|
| 24. FUNERAL DIRECTOR<br><b>Regener Bros</b> | ADDRESS<br><b>6409 Gravois Av</b> | 25. DATE RECD. BY LOCAL REG.<br><b>2-3-59</b> | 26. REGISTRAR'S SIGNATURE<br><b>John C. Murphy M.D.</b> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *John M. Seymour* .....

Licensed Embalmer No. .... 4343 .....

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.**