

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019316

STATE FILE NUMBER

23099

FILED JUN 4 1959

Registration District No.

Primary Registration District No.

Registration No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>3354a So. Grand</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELFRIEDA E. KELLER</b>		4. DATE OF DEATH Month Day Year <b>May 25, 1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 24, 1889</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>dept. store</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
13a. FATHER'S NAME <b>The Rev. Otto Telle</b>		13b. MOTHER'S MAIDEN NAME <b>Louise Bader</b>	14. NAME OF HUSBAND OR WIFE <b>Lucien E. Keller</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>341-20-5941</b>	17. INFORMANT Address <b>Robert St. Keller, St. Joseph, Missouri</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chr. Hypertension chr. arteriosclerosis</b> DUE TO (c) <b>Obesity.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5/20/59</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cushing's ulcers stomach</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Found on floor of hall at home 5/20/59</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <b>no apparent injury but unable to walk</b>		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 <b>5/20/59</b> to <b>5/25/59</b> and last saw her alive on <b>5/25/59</b> Death occurred at <b>2:55 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Eugene A Vogel, M.D.</b>		22b. ADDRESS <b>3325 S Grand Bl</b>	
22c. DATE SIGNED <b>5/26/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE <b>May 27, 1959</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>BEIDERWIEDEN F.H. INC. 1936 St. Louis Ave</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 27 '59</b>	
26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D. G. O.</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr. Eugene A. Vogel,  
3325 So. Gra nd

2-4 PM

### 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. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.