

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019989
STATE FILE NUMBER

DECEASED JUN 9 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 464

300
-57

1. PLACE OF DEATH a. COUNTY St. Louis		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 Manchester	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Wellston 4301	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Manchester Nursing Home	Length of stay in lb 9 mo.	d. STREET ADDRESS (If outside, give location) 1813 Timberlake	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Ira Middle Keidel Last Keidel			4. DATE OF DEATH Month May Day 26 Year 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1880	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	IF UNDER 24 HRS. Hours 1 Min. 1
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer	10b. KIND OF BUSINESS OR INDUSTRY Factory	11. BIRTHPLACE (City and state or country) Tama Co., Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Albert Keidel	13b. MOTHER'S MAIDEN NAME Anna Brockt	14. NAME OF HUSBAND OR WIFE Imogene
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 491-12-7598A	17. INFORMANT Address Miss Ruth Boxdorfer, 1000 Washington Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular renal disease		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) Senility	
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.) 442x
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20c. TIME OF INJURY Hour 9:55 p. 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 Dysart, Iowa	COUNTY Dysart	STATE Iowa
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21. I attended the deceased from Sept 5, 1958 to May 26, 1959 and last saw her alive on May 26, 1959 Death occurred at 9:55 p. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE B. R. Forney M.D.	22b. ADDRESS 13 Allwin Ave.	22c. DATE SIGNED 5-27-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-29-59	23c. NAME OF CEMETERY OR CREMATORY Local Cemetery	23d. LOCATION (City, town, or county) (State) Dysart, Iowa.
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24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.	ADDRESS 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. 5-27-59	REGISTRAR'S SIGNATURE John M. H. [Signature]
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JUN 3 1958

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 *Melvin L. Kemper*

Licensed Embalmer No. *4052*

P. O. Address *4916 Washington St. Iowa 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.

10