

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY Howard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Kokomo	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hospital		d. STREET ADDRESS (If outside, give location) 413 So. Berkley	

3. NAME OF DECEASED (Type or print) First Wilbur Middle Ray Last Keeler			4. DATE OF DEATH Month October Day 2 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/29/1893	9. AGE (last birthday) 67	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HR <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of Drug Store		10b. KIND OF BUSINESS OR INDUSTRY Drugs	11. BIRTHPLACE (City and state or country) Tipton County, Indiana	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Keeler		13b. MOTHER'S MAIDEN NAME Martha Cox		14. NAME OF HUSBAND OR WIFE Hazel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		16. SOCIAL SECURITY NO. 315-10-0949	17. INFORMANT Hazel Keeler, 413 So. Berkley, Kokomo, Ind.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Coronary Thrombosis**
 DUE TO (b) _____
 DUE TO (c) **420.1**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
 PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES <input 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 _____ 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 _____ to _____ and last saw her/him alive on _____
 Death occurred at _____ **215A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Albert H. Hoppe</i>	(Degree or title)	22b. ADDRESS 1300 Elm -	22c. DATE SIGNED 10/4/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-6-60	23c. NAME OF CEMETERY OR CREMATORY Albright Cemetery	23d. LOCATION (City, town, or county) State Howard County, Indiana.
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24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 1700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. OCT 4 1960	26. REGISTRAR'S SIGNATURE <i>Lead Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 14 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Elton R. Remel

Licensed Embalmer No. 4283

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.