

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044468

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10743** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 19 1962

VS 300  
Rev. 4/59

1  
2 **206**

3  
4 **0**

5  
6 **1**

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10

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13 **58**

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>42 yrs</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5254 Wabada</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>WILLIAM</b> Last <b>KELLERHALS</b>			4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>7</b> Year <b>1962</b>			5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1/20/1896</b>		9. AGE (last birthday) <b>66 yrs</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GUARD</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>FACTORY</b>						11. BIRTHPLACE (City and state or country) <b>ST. CHARLES, MISSOURI</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Joseph Kellerhals</b>						13b. MOTHER'S MAIDEN NAME <b>Mary Brockmeier</b>						14. NAME OF HUSBAND OR WIFE <b>Wilhelmina KELLERHALS</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES</b>						16. SOCIAL SECURITY NO. <b>WW 1</b>						17. INFORMANT <b>Mrs. Wilhelmina Kellerhals 5254 Wabada</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>Hodgkins Disease</b> DUE TO (b) _____ DUE TO (c) <b>201X</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause, last.												INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>Biopsy July 2, 1961.</b>												PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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. Month, Day, Year _____				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>1960</b> to <b>Nov 7 1962</b> and last saw him alive on <b>Nov 7 1962</b> Death occurred at <b>8:10 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>R.S. Bands M.D.</b>						22b. ADDRESS <b>5427 Delmar</b>				22c. DATE SIGNED <b>11.8.62</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>Nov. 10, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEMETERY</b>				23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY, MISSOURI</b>											
24. FUNERAL DIRECTOR <b>BEIDERWIEDEN F.H. INC., 1936 ST. LOUIS AVE.</b>						25. DATE RECD. BY LOCAL REG. <b>NOV 8 1962</b>		26. REGISTRAR'S SIGNATURE <b>Boad Smith, M.D.</b>											

USE BLACK INK OR TYPEWRITER RIBBON

DR. ROBERT BASSETT  
5427 DELMAR  
1-5pm Thursday

**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 Homer W. Jritz

Licensed Embalmer No. 3882

P. O. Address St. Louis.

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.