

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011974

STATE FILE NUMBER

FILED APR 15 1959

Registration District No. **333**

Primary Registration District No. **3074**

Registrar's No. **60**

300
1-57 C

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mississippi	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston		c. CITY OR TOWN Charleston 6720	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Delta Comm. Hosp.		d. STREET ADDRESS 206 Matthews	
Length of stay in lb 46 Days		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adele Middle Keller Last Scott			4. DATE OF DEATH Month 4 Day 5 Year 59
5. SEX Female	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 3/4/1877
9. AGE (In years last birthday) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		12. CITIZEN OF WHAT COUNTRY? USA	
10b. KIND OF BUSINESS OR INDUSTRY At home		13. FATHER'S NAME George Keller	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Mary Louise Keller	
14. NAME OF HUSBAND OR WIFE		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. None		17. INFORMANT Address Elizabeth Webb, Charleston, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Angina & Myocarditis			INTERVAL BETWEEN ONSET AND DEATH 3d
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Vascular Accident			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.) OTOX	
20c. TIME OF INJURY Hour _____ a.m. _____ 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 1932 to 4/5/59 and last saw her alive on 4/5/59 Death occurred at 7:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature] (Degree or title)		22b. ADDRESS Charleston Mo	
22c. DATE, SIGNED 4/6/59 (Date)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4/8/59	
23c. NAME OF CEMETERY OR CREMATORY Bellfountaine Cemetery		23d. LOCATION (City, town, or county) St. Louis, Mo.	
24. FUNERAL DIRECTOR The Sunneled Funeral Chapel ADDRESS Charleston, Mo.		25. DATE RECD. BY LOCAL REG. 4-7-59	
26. REGISTRAR'S SIGNATURE [Signature]			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

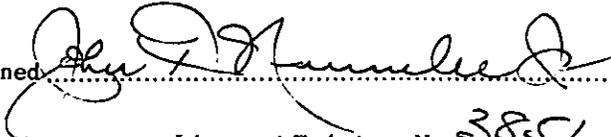
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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. 3851

P. O. Address Charleston

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.