

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046435
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3655

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

1 4005
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

FILED DEC 16 1963	
1. PLACE OF DEATH	
a. COUNTY St. Louis.	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN RICHMOND HEIGHTS Clayton	a. STATE Missouri. b. COUNTY St. Louis.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital.	c. CITY OR TOWN Clayton. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. STREET ADDRESS 25 Dartford Ave. (63105)	d. STREET ADDRESS (If outside, give location) 25 Dartford Ave. (63105) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	
First ESTELLE	Middle H.
Last KELLAR.	4. DATE OF DEATH Month November Day 27 Year 1963.
5. SEX F.	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 2-25-1881
9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife.	10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (City and state or country) Washington, Ind.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME William M. Hayes.	13b. MOTHER'S MAIDEN NAME Winifred Lee.
14. NAME OF HUSBAND OR WIFE Clyde B. Kellar.	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.	17. INFORMANT JOHN W. KELLAR - 25 DARTFORD AVE
18. CAUSE OF DEATH (Enter only one cause per line)	
PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) exhaustion	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) Pulmonary Tuberculosis	Recent
DUE TO (c) Rheumatoid Arthritis	4 yrs
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. <input type="checkbox"/> Yes <input checked="" 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 Sept 1940 to 11/27/63 and last saw her alive on 11/27/63 Death occurred at about 4:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Daniel P. Axtell M.D. (Degree or title)	22b. ADDRESS 634 N Grand Ave
22c. DATE SIGNED 11/29/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 12-2-63.
23c. NAME OF CEMETERY OR CREMATORY St. John's	23d. LOCATION (City, town, or county) Washington, Indiana.
24. FUNERAL DIRECTOR Buchholz Mortuary, Inc. 5967 West	25. DATE RECD. BY LOCAL REG. 11-29-63
26. REGISTRAR'S SIGNATURE John B. Mungley M.D.	

USE BLACK INK OR TYPEWRITER RIBBON

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 Roger C. Linderus

Licensed Embalmer No. 4275

P. O. Address St. Louis, 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.