

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

19002

1. PLACE OF DEATH

County St. Louis, Mo. Registration District No. 791
 Township..... Primary Registration District No. 1003
 City..... (No. City Infirmary) St. Ward.....

File No.
 Registered No. 5415
 St. Ward.....

2. FULL NAME

William Koelmann
 (a) Residence. No. 5800 Arsenal St. 13 Ward.
 (Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rose Koelmann
April 16, 1861
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 17, 1928
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 1 +
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Cabinet maker
 (b) General nature of industry, business, or establishment in which employed (or employer) Retired
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Germany
 (STATE OR COUNTRY)
 10. NAME OF FATHER Casper Koelmann
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Annie Waldman
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY)

14. INFORMANT Mrs. M. Effinger
 (Address) 5800 Arsenal St.
 15. FILED May 28 1928 May C. Stanley
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 17, 1928
 17. I HEREBY CERTIFY, That I attended deceased from July 23, 1924 to May 17, 1928
 that I last saw him alive on May 7, 1928, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ch. Myocarditis
9015
 CONTRIBUTORY Senility
 (SECONDARY) (duration) ? yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? No DATE OF.....
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS Ralph Berg, M. D.
 (Signed)..... (Address) 5800 Arsenal St.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Woods Cemetery DATE OF BURIAL May 19, 1928
 20. UNDERTAKER Rehman Haral ADDRESS 1905 Union

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

