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

Do not use this space.

31915

1. PLACE OF DEATH

County .... Registration District No. 791 | File No. ....

Township .... Primary Registration District No. 1063 | Registered No. 8934

City .... (No. 5845 Wabada Ave .... St. .... Ward)

2. FULL NAME Frank F. Koeller

(a) Residence. No. 5845 Wabada St., 6 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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

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: Minnie L. Koeller

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 1-19-1875

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	54	7	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Board of Education
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): St Louis
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: Frank Koeller

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Holland.

12. MAIDEN NAME OF MOTHER: Mary Heathveld

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Holland.

14. INFORMANT: Minnie L Koeller
(Address): 5845 Wabada Ave

15. FILED: SEP -3 19.. Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept -1- 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 15th, 1929, to Sept 1st, 1929

that I last saw h... alive on ...., 19...., and that death occurred, on the date stated above, at 3.30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Encephalitis Lethargic

17 ... (duration) ... yrs. ... mos. 17 ds.

CONTRIBUTORY (SECONDARY) ... (duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ....

DID AN OPERATION PRECEDE DEATH? .... DATE OF ....

WAS THERE AN AUTOPSY? ....

WHAT TEST CONFIRMED DIAGNOSIS? ....

(Signed) Theo W Congelman, M. D.

9/2, 1929 (Address) 5043 Vernon Ave

*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: St. Peters Cem. | DATE OF BURIAL: 9-4-1929

20. UNDERTAKER: H. A. Stock Und. Co. | ADDRESS: 2117 E. Grand

253 1 13 8 23

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.

[illegible]

5043 V[illegible]