

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.

APR 25 1934

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

Do not use this space.

10481

1. PLACE OF DEATH
 County _____ Registration District No. **791**
 Township **St. Louis** Primary Registration District No. **1003** File No. _____
 City **St. Louis** (No. **Isolation Hospital**) Registered No. **2290** St. _____ Ward _____

2. FULL NAME **Mary M. Koeln**
 (a) Residence, No. **6716 Michigan St.** 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female**
 4. COLOR OR RACE **white**
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **single**

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Oct. 5, 1927**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
6 5 0

OCCUPATION
 8. Trade, profession, or particular kind of work done, as splanner, sawyer, bookkeeper, etc. **nil**
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

FATHER
 13. NAME **Joseph Koeln**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

MOTHER
 15. MAIDEN NAME **Margaret Palmer**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

17. INFORMANT **Grace Barry**
 (ADDRESS) **5600 Windsor St.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Mt. Hope Cem.** DATE **3-8-34**

19. UNDERTAKER **St. Ann's Hosp. & P. Co.**
 (ADDRESS) **784 1/2 Broadway**

20. FILED **6** 19 **34**
J. Brebeck Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Mar 5, 1934**

22. I HEREBY CERTIFY, That I attended deceased from **Mar 5, 1934**, to **Mar 5, 1934**
 I last saw her alive on **Mar 5, 1934** Death is said to have occurred on the date stated above, at **7:00 A.M.**
 The principal cause of death and related causes of importance were as follows:
Diphtheria faucial
Rhynchopharyngeal & tracheal
100A
38A
10
 Other contributory causes of importance:
toxic Myocarditis

Name of operation **Emergency Tracheotomy** of **3-5**
 What test confirmed diagnosis? **Clinical** Was there an autopsy? **No**

23. If death was due to external cause (violence), fill in also the following:
 Accident, suicide, or homicide? **No** Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) **John E. Schenck** M. D.
 (Address) **Isolation Hospital**

