

Registration District No. 307

Primary Registration District No. 5425

Registrar's No.

1. PLACE OF DEATH:

(a) County Gasconade  
(b) City or town Rural, Boulevard township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Rural Bay, Mo. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community about 55 yrs. (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Bay Missouri  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 28  
year 1941 hour 7 minute 30 A. M.  
21. I hereby certify that I attended the deceased from March 11<sup>th</sup>  
1938 to February 28<sup>th</sup>, 1941;  
that I last saw her alive on February 21<sup>st</sup>, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 3 years

Due to Atherosclerosis

Due to \_\_\_\_\_

Other conditions HTA  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy No autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 278  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature E. G. Rhodius (M. D. or other) 0  
Address Bay Mo Date signed 3/28/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

3. (a) PRINT FULL NAME Anna Koelling

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife Theo Koelling 6. (c) Age of husband or wife if alive DEAD years

7. Birth date of deceased JAN. 24 1853  
(Month) (Day) (Year)

8. AGE: Years 88 Months 1 Days 04 If less than one day hr. \_\_\_\_\_ min. 9

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWORK

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Meyer

18. Birthplace Germany (City, town, or county) (State or foreign country)

14. Maiden name Christine Krueger

15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Fred Leimbuehler

(b) Address Bay Missouri

17. (a) BURIAL (b) Date thereof 3-2-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: GIEDENNACEN CEM.

18. (a) Signature of funeral director W.F. Gottenstrater

(b) Address Owensville Mo

19. (a) 3-1-1940 (b) Edna F. Meyer  
(Date received local registrar) (Registrar's signature)

**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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed W.F. Gottenstracter

Licensed Embalmer No. 1444

P. O. Address Owensville, 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 this body is not embalmed, above space should be left blank.**

Registration District No. 307

Primary Registration District No. 2425

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Wagoner  
(b) City or town Bowling Green, T. P.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Anna Koelling

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 88 Months 1 Days 4 If less than one day \_\_\_\_\_ min.

9. Birthplace Paris, Kansas (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 6-14-44 (b) Ann F. B. Meyer (Date received/local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature E. G. Rhodius (M. D. or other) \_\_\_\_\_

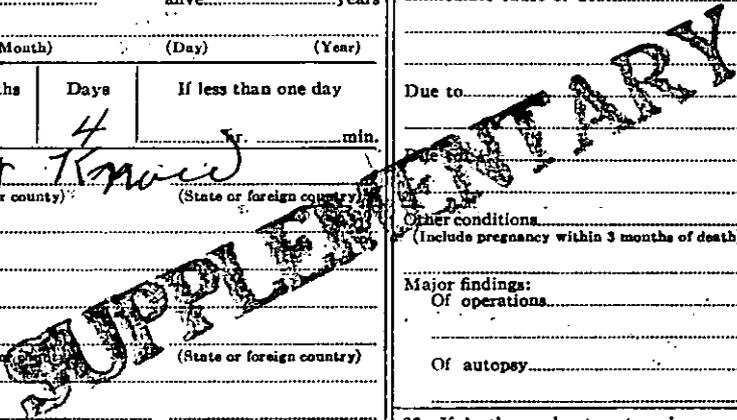
Address Bay Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD



1941  
5-10634

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**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, fact should be so stated above.**