

No. 2
-1-441
5-17-39
X28390

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH

FILED NOV 24 1941 791

STANDARD CERTIFICATE OF DEATH

State File No. **33207**
Registrar's No. **8162**

Registration District No.

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4338 Lexington Ave. /
(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 **Missouri.** (b) County.....
(c) City or town **St. Louis.**
(If outside city or town limits, write "RURAL")
(d) Street No. **4338 Lexington Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **11**
year **1941** hour **7** minute **25** P. M.
21. I hereby certify that I attended the deceased from **10-1-41**
10. 4. 19**41** to..... 19.....
that I last saw **him** alive on **10 4 41** 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary Occlusion** Duration
Acute Occlusion of Heart 1 day
4.

Due to.....
Due to.....
Other conditions: **Chronic Nephritis** 3 yrs
(Include pregnancy within 3 months of death)
Major findings: **Chronic Nephritis** 3 yrs
Of operations.....
Of autopsy.....
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **August F. Koelkebeck.**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **493-05-0448**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married.**

6. (b) Name of husband or wife **Elizabeth Koelkebeck** 6. (c) Age of husband or wife if alive **53** years

7. Birth date of deceased **April 1 1876.**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	65	6	10	hr. min.

9. Birthplace **St. Louis, Missouri.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Chemist Helper.**

11. Industry or business **Union Electric Of Mo.**

12. Name **August Koelkebeck.**

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

14. Maiden name **unknown**

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

16. (a) Informant **Elizabeth Koelkebeck.**

(b) Address **4338 Lexington Ave.**

17. (a) **Burial** (b) Date thereof **10-15-41.**
(Burial, cremation, or reinterment) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cem.**

18. (a) Signature of funeral director **H.V. Leidner Und.Co.**

(b) Address **2223 St. Louis Ave.**

19. (a) **OCT 14 1941** (Date received local registrar) **J. F. Presich** (Registrar's signature)

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?

(Specify type of place) (e) Means of injury.....
While at work?.....
23. Signature **J. F. Presich** (M. D. or other)
Address **1875 Maple** Date signed **10/13/41**

(Licensed Embalmer's Statement on Reverse Side)

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

20
17
9

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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 Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2223 St. Louis

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.