

Registration District No. **310**

Primary Registration District No. **3058**

Registrar's No. **23**

1. PLACE OF DEATH:

(a) County **St. Charles mo.**

(b) City or town **St. Charles mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Joseph Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lincoln**

(c) City or town **Hawkpoint mo.**
(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 **W.M. SAMUEL KOESTER**

3. (b) If veteran, name war **None**

3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **14**
year **1944** hour **3** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Jan 2**, 1944 to **Jan 14**, 1944
that I last saw him alive on **Jan 14**, 1944
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **W**

6. (a) Name of husband or wife **Marie** 6. (c) Age of husband or wife if **55** years
Mary Koester alive

7. Birth day of deceased **April 23 1885**
(Month) (Day) (Year)

Immediate cause of death **Myocarditis**

Due to **Not known**

Due to.....

8. AGE:

Years	Months	Days	If less than one day
58	26	21hr.min.

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

10. Usual occupation **Retired**

Other conditions **Diphtheria Bronchitis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **9321**

Of autopsy.....

11. Industry or business

12. Name **John Koester**

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

14. Maiden name **Mary Slater**

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant **Frankie Mary Koester**

(b) Address **St. Charles mo**

17. (a) Removal (b) Date thereof **Jan 16, 44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hawkpoint mo**

18. (a) Signature of funeral director **Wayne Mc Coy**

(b) Address **Troy mo**

19. (a) 2-15-44 (b) **Claret E. Paul**
(Date received local registrar) (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 **Joe J. [unclear]** (M. D. or other)
Address **St. Charles mo** Date signed **1-24-44**

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

92
9
3

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 3-15-44

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..... *Wayne McCoy*
Licensed Embalmer No. *3586*
P. O. Address..... *Troy 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, fact should be so stated above.