

FILED DEC 7 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 3017

1. PLACE OF DEATH:

(a) County COOPER  
(b) City or town BOONVILLE  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
ST. JOSEPH'S HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 39 YEARS  
(Specify whether  
In this community 39 YEARS  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County COOPER  
(c) City or town BOONVILLE  
(If outside city or town limits write "RURAL")  
(d) Street No. ST. JOSEPH'S HOSPITAL  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? 0 years.

3. (a) PRINT FULL NAME SISTER MARY GERTRUDE KOECHNER O.S.B.

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased MAY 1877  
(Month) (Day) (Year)

8. AGE: Years 67 Months  Days  If less than one day hr. min.

9. Birthplace TIPTON MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation RELIGIOUS NUN

11. Industry or business HOSPITAL SUPERINTENDENT

12. Name ADOLPH KOECHNER

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

14. Maiden name ELLEN MEYER

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

16. (a) Informant HOSPITAL RECORDS

(b) Address BOONVILLE, MO.

17. (a) BURIAL (b) Date thereof 11/21/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LOURDES SHRINE

18. (a) Signature of funeral director STEGNER & KOENIG

(b) Address BOONVILLE, MO.

19. (a) NOV-20-44 (b) DR Chas. Swap.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER, 19th  
year 1944 hour 8:30 minute A.M.

21. I hereby certify that I attended the deceased from July, 1942, to Nov 19, 1944  
that I last saw him alive on Nov 19, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary heart disease (occlusion) Duration 2 yrs

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

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

Other conditions none (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 J. C. Beckett M.D. (M.D. or other)

Address Boonville mo Date signed 11-20-44

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

MOTHER FATHER

RECEIVED

Health Officer No. 8,

Dict File Number

Dicte Filed 12-5-47

**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 James W. Seeger

Licensed Embalmer No. 3780

P. O. Address Boonville, 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.**