

**FILED JAN 4 1945**

Primary Registration District No. **6048**

Registrar's No. **227**

1. PLACE OF DEATH:

(a) County **O'Fallon**  
(b) City or town **St. Charles**  
(c) Name of hospital or institution: **St. Charles**  
(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 **Mo** (b) County **St. Charles**  
(c) City or town **O'Fallon**  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **19**  
year **1944** hour **10** minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from **July 1940** to **Dec. 19 1944**  
that I last saw him alive on **Dec. 19 1944**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Myocarditis**  
Duration **3 yrs**  
Due to \_\_\_\_\_  
Due to **93d**

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 **Nicholas J. Homick** (M. D. or other)  
Address **O'Fallon, Mo.** Date signed **1/20/44**

3. (a) PRINT FULL NAME

**John Koester**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **Rosa Arnold** 6. (c) Age of husband or wife if alive **69** years  
7. Birth date of deceased **Feb. 24 1875**  
(Month) (Day) (Year)

8. AGE: Years **69** Months **9** Days **15** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Augusta Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

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

MOTHER FATHER { 12. Name **Wm. Koester**  
13. Birthplace **Augusta Mo**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Anna Cordes**  
15. Birthplace **St. Louis Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Rosa Koester**

(b) Address **O'Fallon Mo**

17. (a) **Burial** (b) Date thereof **Dec. 22 - '44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **O'Fallon Mo**

18. (a) Signature of funeral director **E. Kautley**

(b) Address **O'Fallon Mo**

19. (a) **Dec. 20 - 44** (b) **E. Kautley**  
(Date received local registrar) (Registrar's signature)

**632**

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

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed 1-3-45

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

*E. Keithly*

Licensed Embalmer No.

824

P. O. Address

*Fallon 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.