V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35501

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10400

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: 4829 Greer Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (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. 4829 Greer Ave
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Olivia W. Koestner

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 Married

6. (b) Name of husband or wife Henry J. Koestner

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Nov. 7, 1885
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
60	0	21	hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation At home

11. Industry or business

FATHER
12. Name Philip Goebel
13. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Christina Primus
15. Birthplace St. Louis (City, town, or county) Mo. X (State or foreign country)

16. (a) Informant Henry J. Koestner
(b) Address 4829 Greer Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/45 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Math Hermann & Son
(b) Address 2161 East Fair Ave

19. (a) NOV 30 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Nov. day 28, year 1945 hour 7:30 PM. minute M.

21. I hereby certify that I attended the deceased from Oct 5. 1945, 19, to Nov. 28. 1945, 19; that I last saw her alive on Nov. 28, 1945, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage (R+ Cerebrum) — Duration 4 days

Due to Hypertension — 2 yrs

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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? Dr. F. J. Medler (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 4114 N. Florissant (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address 4114 N. Florissant Date signed 12/1/45

F. J. Medler

(Licensed Embalmer's Statement on Reverse Side)

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 William G Burkholz

Licensed Embalmer No. 2160

P. O. Address St Louis 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.