

FILED **Oct 6 1945**

Registration District No. 02

Primary Registration District No. 5323

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Dade
 (b) City or town Golden City Rural Grant Twp.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 40 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Dade 29
 (c) City or town Golden City
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME CLARA ROSA KOEHLER
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 25
 year 1945 hour 10 minute 50 M.

4. Sex Female 5. Color or race white
 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Martin Koehler 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: December 26 1862
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 23 1945 to Oct 25 1945
 that I last saw him Fr. alive on Oct 24 1945
 and that death occurred on the date and hour stated above.

8. AGE: Years 82 Months 9 Days 29
 If less than one day hr. _____ min. _____

Immediate cause of death: Carbuncle hemorrhage due to arterio sclerosis
 Due to arterio sclerosis present for at least 10 years
 Duration 3 days

9. Birthplace Ober Planitz Germany
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

Other conditions: _____
(Include pregnancy within 3 months of death)

11. Industry or business _____

Major findings: gland
 Of operations: _____
 Of autopsy: _____
 PHYSICIAN: _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 12. Name unknown
 13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
 14. Maiden name unknown
 15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Arno Heustein
 (b) Address Lockwood, Mo.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

17. (a) burial (b) Date thereof Oct. 28, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? _____

(c) Place: burial or cremation I.O.O.F. Cem. Golden City, Mo.

(Specify type of place)
 While at work? _____ (c) Means of injury _____

18. (a) Signature of funeral director Phillips Funeral Home
 (b) Address Golden City, Mo.

23. Signature [Signature] (M. D. or other) MD
 Address Golden City Mo Date signed 10-26-45

19. (a) 10-28 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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

29
0
0

1412

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.....

Licensed Embalmer No. 3278

P. O. Address. Golden City, 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.