. S. No. 2
DM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 8 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40791

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 427

1. PLACE OF DEATH:
(a) County: Cape Girardeau
(b) City or town: Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 hour (Specify whether years, months or days)
In this community: 6 months

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

3. (a) PRINT FULL NAME: FREDERICK ANDREW KOEHLER
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: Male
5. Color or race: white
6. (a) Single, widowed, married, divorced: ✓
6. (b) Name of husband or wife: ✓
6. (c) Age of husband or wife if alive: ✓ years
7. Birth date of deceased: June (Month) 19, (Day) 1945 (Year)

8. AGE: Years	Months	Days	If less than one day
	6	6	hr. min.

9. Birthplace: Orlando (City, town, or county) Florida (State or foreign country)
10. Usual occupation: ✓
11. Industry or business: ✓
MOTHER FATHER
12. Name: Melbourne Koehler
13. Birthplace: near Jackson Mo (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Bernice Sayer
15. Birthplace: Cape Girardeau Mo (City, town, or county) (State or foreign country)
16. (a) Informant: Melbourne Koehler
(b) Address: Jackson Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 26 -45 (Month) (Day) (Year)
(c) Place: burial or cremation: Koehler Cemetery
18. (a) Signature of funeral director: P.G. Miller
(b) Address: Jackson
19. (a) 12-27-1945 (Date received local registrar) (b) H. C. Summers (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 25 year 1945 hour 12 minute 10 A.M.
21. I hereby certify that I attended the deceased from Dec 24, 1945 to Dec 25, 1945 that I last saw him alive on Dec 24, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchial Pneumonia	48 hrs
Due to: ?	
Due to:	
Other conditions: Mongoloid (congenital) (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: 107

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? (Specify type of place)
While at work? (e) Means of injury: 0
23. Signature: T. E. Ruff (M. D. or other) MD
Address: Jackson mo Date signed 12/26/45

1509

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 146-1506

Date Filed 1-7-46

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 J. P. Graham

Licensed Embalmer No. 4010

P. O. Address Lutesville, 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.