

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9863

State File No. _____

Registration District No. 179

Primary Registration District No. 5669 4289

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Hawkpoint
(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 _____ (Specify whether)
In this community In This Community (Specify whether)
years, months or days 31 years

3. (a) PRINT FULL NAME MARY ELLEN KOESTER

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

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 13 1864
(Month) (Day) (Year)

8. AGE: Years 82 Months 4 Days 7
If less than one day _____ hr. _____ min.

9. Birthplace Lincoln County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Samuel Slater

13. Birthplace Lincoln County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Hunter

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

16. (a) Informant Mary Koester

(b) Address Hawkpoint Mo.

17. (a) Burial (b) Date thereof 3-30-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hawkpoint Cemetery

18. (a) Signature of funeral director Wayne Mc Coy

(b) Address Troy Missouri

19. (a) 3-31-47 (b) Emmie Ribble
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln
(c) City or town Hawkpoint
(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 March day 27
year 1947 hour 3 minute 15 P. M.

21. I hereby certify that I attended the deceased from March 27 1947 to March 27 1947
that I last saw her alive on March 27 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chronic Endocarditis
and Bronchial Pneumonia
Due to _____

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

Major findings: Of operations _____
Of autopsy _____

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 2

23. Signature Dr. C. Althoff (M. D. or other) DO.
Address Troy, Mo. Date signed 3/27/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 4-8-47

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..... *Wayne McCoy*
Licensed Embalmer No. *3586*
P. O. Address *Jroy 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.