

S. No. 2
OM-5-43
v. 5-17-39
X36671

21322

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 203

FILED JUL 10 1947

Registration District No. 146

Primary Registration District No. 5568

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

1. PLACE OF DEATH:

(a) County Jackson *Rural Blue*

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
518 Brookside
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community 39 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson *48*

(c) City or town Kansas City *Rural*
(If outside city or town limits, write "RURAL")

(d) Street No. 518 Brookside
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John G. Koehly

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Dec.

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

7. Birth date of deceased Jan. 10 1882
(Month) (Day) (Year)

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

| | | | |
|----|---|----|----------|
| 65 | 5 | 14 | hr. min. |
|----|---|----|----------|

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

10. Usual occupation Retired Custodian

11. Industry or business School Board

MOTHER FATHER

12. Name Joseph Koehly

13. Birthplace Alcasace Lorraine
(City, town, or county) (State or foreign country)

14. Maiden name Therese Peters

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

16. (a) Informant George Koehly

(b) Address 518 Brookside

17. (a) Burial (b) Date thereof 6-27-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Mary's

18. (a) Signature of funeral director J. P. Sheil

(b) Address Kansas City

19. (a) 6-26-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Feb. 1947
June 29 1947 that I last saw him alive on June 23 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive heart disease

Due to Arterio Sclerosis

Duration 1 yr

Due to _____ Duration 4 yrs

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? _____
(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 [Signature] (M. D. or other) _____

Address 1215 Rioblt Bldg Date signed 6/25/47

(Licensed Embalmer's Statement on Reverse Side)

AUG 18 1947

Rec'd No 1504

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. Scheil

Licensed Embalmer No. 3625

P. O. Address. R. C. 310

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.