

FILED SEP 2 1947

Registration District No. **218**

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
4135 Magnolia Ct.
(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 Years

3. (a) PRINT FULL NAME Theodore A. Koetzli

3. (b) If veteran, name war _____

3. (c) Social Security No. No

4. Sex Male **5. Color or race** White

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

6. (b) Name of husband or wife Ida Haddaway Koetzli

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

7. Birth date of deceased Oct 19 1872
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>10</u>	<u>1</u>	hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER { **12. Name** Theophilus J. Koetzli 5

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

14. Maiden name Doris Homeyer

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

16. (a) Informant Julia Koetzli (Sister)

(b) Address 4135 Magnolia Ct.

17. (a) (Burial, cremation, or removal) Cremation **(b) Date thereof** Aug 22 1947
(Month) (Day) (Year)

(c) Place: burial or cremation Mo. Crematory
C. Hoffmeister Colonial Mortuary

18. (a) Signature of funeral director _____

(b) Address 6464 Chippewa St.

19. (a) (Date received local registrar) AUG 21 1947 **(b) Registrar's signature** J. P. Bredbeck

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. 4135 Magnolia Ct.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 20
year 1947 hour 8:30 minute 9 M.

21. I hereby certify that I attended the deceased from February 8 1945 to August 20 1947
that I last saw him alive on June 19 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Cardio-Vascular-Renal Disease 2 yrs.

Due to usual

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: none

Of operations _____

Of autopsy none

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? _____

23. Signature Leon C. Stahl (M. D. certifier)
Address 1504 So. Grand Blvd Date signed 8/21/47

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

Dr. Leon Haile
1504 So. Grand
4049 Magnolia

GR 2828
PR 6628

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 *Linus C. Hoffmeister*
Licensed Embalmer No. *3871*
P. O. Address *7814 S. Broad*

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.