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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED SEP 18 1947**

STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

32209

State File No. ....

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 153

**1. PLACE OF DEATH:**

(a) County ST. CHARLES  
(b) City or town St. Charles  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
619 N. Kingshighway  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... (Specify whether  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Charles  
(c) City or town St. Charles  
(If outside city or town limits, write "RURAL")  
(d) Street No. 619 N. Kingshighway  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.....

**3. (a) PRINT FULL NAME** Fred P. Kolb

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

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Hattie Hafer 6. (c) Age of husband or wife if alive 54 years  
7. Birth date of deceased April 23, 1892  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
55 4 2 hr. min.

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

10. Usual occupation Laborer

11. Industry or business.....

MOTHER FATHER

12. Name Fred Kolb  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Roth  
15. Birthplace Not Known  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Hattie Kolb  
(b) Address St. Charles, Mo.

17. (a) Burial (b) Date thereof Aug. 28, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lutheran Cemetery

18. (a) Signature of funeral director Hackman - Bone  
(b) Address 326 N. 6th. Str., St. Charles, Mo.

19. (a) 8-31-47 (b) Fannie Hamilton  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug. day 25  
year 1947 hour 11 minute 45 P.A.M.

21. I hereby certify that I attended the deceased from  
Feb. 3, 1947, to Aug 25, 1947  
that I last saw him alive on Aug 21, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death CORONARY Thrombosis Duration

Due to Angina Pectoris 1 1/2 Months

Due to Essential Hypertension 7 Months

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 W. J. Jones (M. D. or other) MD  
Address 114 N. Main St. Charles, Mo Date signed 8-27-47

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

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed SEP 17 1947

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 *Arthur C. Gunn*

Licensed Embalmer No. *3154*

P. O. Address *St Charles, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 001

IX 43880

Registration District No. 310

Primary Registration District No. 305-8

Registrar's No. 153

1. PLACE OF DEATH:

(a) County St Charles

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

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

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Fred P. Koef

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased April 23  
(Month) (Day) (Year)

8. AGE: Years 55 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) mo

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) 8/31/47 (b) Frank Hanceley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_ year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

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? \_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-32209