

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25011

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1005** Registrar's No. **6477**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. CITY (If outside corporate limits, write RURAL and give township) Venice	
c. LENGTH OF STAY (In this place) (1)		d. STREET ADDRESS (If rural, give location) 527 Washington 20	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Henry c. (Last) Koelker		4. DATE OF DEATH (Month) (Day) (Year) 7 23 49	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 11-24-1893
9. AGE (In years last birthday) 7.5		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman	10b. KIND OF BUSINESS OR INDUSTRY Power house
11. BIRTHPLACE (State or foreign country) Effingham Ill		12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME unk		13b. MOTHER'S MAIDEN NAME unk	
14. NAME OF HUSBAND OR WIFE Mary			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 	
17. INFORMANT'S SIGNATURE & NAME Harold Koelker		ADDRESS Venice, Ill	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Quemosis Hypostatic		INTERVAL BETWEEN ONSET AND DEATH 3 days	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerotic Heart Disease 2 yrs DUE TO (c) Arterio sclerosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Enlarged prostate			
19a. DATE OF OPERATION 7/15/49		19b. MAJOR FINDINGS OF OPERATION Enlarged prostate + bladder stone	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 99			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? HSD			
22. I hereby certify that I attended the deceased from 7-13 1949 to 7-23 1949 , that I last saw the deceased alive on 7/23 1949 , and that death occurred at 7 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE B. J. Mc Gehee (Degree or title)		23b. ADDRESS 11 Hampton Way, Alton	
23c. DATE SIGNED 7/25/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-23-49	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cem		24d. LOCATION (City, town, or county) (State) Edwardsville Twp Ill	
DATE REC'D BY LOCAL REG. JUL 26 1949		REGISTRAR'S SIGNATURE J. B. Luster	
FUNERAL DIRECTOR'S SIGNATURE Francis J. Cahay		ADDRESS Madison, Ill	

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

Sealed

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6477

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed J. Allen Davis Jr
Licensed Embalmer No. 4053

P. O. Address St Louis 10 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.