

FILED SEP 5 1950

STANDARD CERTIFICATE OF DEATH

State File No. 28376

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7254**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		e. STREET ADDRESS (If rural, give location) 5349-N. Kingshighway	

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) Henry	c. (Last) Koehne	4. DATE OF DEATH (Month) (Day) (Year) Aug. 24 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 29, 1890	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 100 Hrs. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping clerk	10b. KIND OF BUSINESS OR INDUSTRY Retail Hardware	11. BIRTHPLACE (State or foreign country) Alton, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Henry Koehne	13b. MOTHER'S MAIDEN NAME Mary Ryan	14. NAME OF HUSBAND OR WIFE Ada Koehne
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY No. 493-01-2442	17. INFORMANT'S SIGNATURE OR NAME Phyllis Koehne ADDRESS 2719 Lexington St. St. Louis, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH undisclosed
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Sclerosis		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Congestive heart failure		Reveal mo	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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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? 4-24-50 4-201
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22. I hereby certify that I attended the deceased from **1-28, 1949**, to **results**, 19____, that I last saw the deceased alive on **6-1, 1950**, and that death occurred at **4-20** m., from the causes and on the date stated above.

23a. SIGNATURE Drew Little (Degree or title) M.D.	23b. ADDRESS 3720 Washington St. St. Louis, Mo.	DATE SIGNED 8/25/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 28, 1950	24c. NAME OF CEMETERY OR CREMATORY St. Peter's	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY _____ REG. AUG 25 1950	REGISTRAR'S SIGNATURE J. B. Bruster	25. FUNERAL DIRECTOR'S SIGNATURE Robert H. Strooper ADDRESS Alton, Ill.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed Robert H. Streep

Licensed Embalmer No. 2474

P. O. Address Alton, Ill.

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.