

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **37341****9471**

FILED OCT 27 1953

REG. DIST. NO. **318**PRIMARY REG. DIST. NO. **1003**

Registrar's No.

BIRTH NO.

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis**

c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION **Enroute City Hospital**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE **Mo.**b. COUNTY **St. Louis**c. CITY OR TOWN **Overland 407**d. Is Residence within limits of a city or incorporated town? Yes No e. STREET ADDRESS (If rural, give location) **9406 Bataan Dr.**

3. NAME OF DECEASED

a. (First)

WILLIAM

b. (Middle)

J.

c. (Last)

KOESTLIN4. DATE OF DEATH (Month) (Day) (Year) **Sep. 30 1953**

5. SEX

Male

6. COLOR OR RACE

White7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Single**

8. DATE OF BIRTH

Jan. 18, 19039. AGE (In years last birthday) **50**

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer-Greyhound**10b. KIND OF BUSINESS OR INDUSTRY **Bus Co.**11. BIRTHPLACE (City and State or Foreign Country) **Edwardsville, Ill.**

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME

William Koestlin

13b. MOTHER'S MAIDEN NAME

Sallie Weeks

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No**

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS **William Koestlin 9406 Bataan Dr.**

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, ashenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES

Morbid 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.

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

Myocardial Infarction

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? **4201**22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **1030P.m.**, from the causes and on the date stated above.

23a. SIGNATURE

Patrick C. Taylor Coroner

(Degree or title)

23b. ADDRESS

1300 Clark

23c. DATE SIGNED

10.2.53

24a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24b. DATE

Oct. 3, 1953

24c. NAME OF CEMETERY OR CREMATORY

Memorial Park Cemetery

24d. LOCATION (City, town, or county) (State)

St. Louis Co., Mo.DATE REC'D BY LOCAL **OCT 2 1953**

REGISTRAR'S SIGNATURE

Carl Smith MD

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

Kriegshauser 4228 S. Kingshighway Bl.

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.....
Signature of Student Embalmer

Signed *Richard W. Storosa*.....

Licensed Embalmer No. *4007*.....

P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.