

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10775**

FILED **APR 7 1954**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **719**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marvin Terrace		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marvin Terrace	
c. LENGTH OF STAY (in this place) 9 Mo.		d. STREET ADDRESS (If rural, give location) 3622 Calvert Ave/	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3622 Calvert Ave.			

3. NAME OF DECEASED (Type or Print) Julia Koelling			4. DATE OF DEATH March 21 1954	
a. (First)	b. (Middle)	c. (Last)	8. DATE OF BIRTH Sept. 25 1886	9. AGE (In years last birthday) 67
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.	
			12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME James Clark		13b. MOTHER'S MAIDEN NAME Mary Daly		14. NAME OF HUSBAND OR WIFE Harry Koelling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Harry Koelling ADDRESS 3622 Calvert Ave.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident (Stroke)		DUE TO (b) Essential hypertension		48^h	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) atherosclerosis		5 yrs	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Infirmities of old age					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **3-19**, 19**54**, to **3-21**, 19**54**, that I last saw the deceased alive on **3-21**, 19**54**, and that death occurred at **9:30 A** m., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)		23b. ADDRESS 2335 Brown Bl. St. Louis		23c. DATE SIGNED 3-22-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE March 24 1954		24c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cem.	
		24d. LOCATION (City, town, or county) St. Louis County		(State) Mo.	

DATE REC'D BY LOCAL REG. 3/22/54		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS 10123 St. Charles Rd	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

W 164500 Bannan & Fortland
Dr. Rance

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address 10123 St. Charles

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.