

pt. Health,
, & Welfare
S. Public
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43068

FILED NOV 19 1957

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2666

S. 300
v. 1-51
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1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) - TOWN <u>Normandy Village</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D'Sullivan Nursing Home</u>		Length of stay in lb <u>6 mo.</u>	d. STREET ADDRESS (If outside, give location) <u>6115 Ella Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED <u>John Koestner</u> (Type or print)		First <u>John</u> Middle <u>Koestner</u> Last <u>Koestner</u>	e. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1957</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 13 1869</u>
9. AGE (In years last birthday) <u>87</u>		10. FUNDER 1 YEAR Months <u>4</u> Days <u>22</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hardware Clerk (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	11. BIRTHPLACE (City and state or country) <u>Smithton, Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>John Koestner</u>	
13b. MOTHER'S MAIDEN NAME <u>Katherine Helgoth</u>		14. NAME OF HUSBAND OR WIFE <u>Bessye Koestner (Deceased)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mrs. Christine Ploggenburg</u> Address <u>6115 Ella Av</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardiac decompensation</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 month</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4221</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>3:25</u> Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY <u>St. Louis</u> STATE <u>Missouri</u>	
21. I attended the deceased from <u>April 1, 1957</u> to <u>Oct 28, 1957</u> and last saw him alive on <u>Oct 24, 1957</u> Death occurred at <u>3:25 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Herbert S. Ploggenburg M.D.</u> (Degree or title)		22b. ADDRESS <u>8231 Clayton Rd</u>	22c. DATE SIGNED <u>11/28/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 31 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>
24. FUNERAL DIRECTOR <u>Math Hermann & Son, Inc.</u> ADDRESS <u>2161 E. Fair</u>		25. DATE RECD. BY LOCAL REG. <u>11/10-28-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert S. Ploggenburg M.D.</u> <u>all</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Gene W. Day*

Licensed Embalmer No. *3737*

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.