

Health,
Welfare
Public
Service

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

FILED MAR 31 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012634
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 545 Registrar's No. 814

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, give TOWNSHIP only) OR TOWN MAPLEWOOD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN MAPLEWOOD 4544 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3320 GREENWOOD		d. STREET ADDRESS (If outside, give location) 3320 GREENWOOD Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHRISTINE Middle KOETTING Last KOETTING		4. DATE OF DEATH MAR. 20. 1958 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 7. 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (City and state or country) EVANSVILLE ILL.	
13a. FATHER'S NAME PAUL PAUTLER		14. NAME OF HUSBAND OR WIFE HENRY KOETTING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NOT		16. SOCIAL SECURITY NO. NONE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic heart disease. DUE TO (b) Cerebral Hemorrhage DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200		19. WAS AUTOPSY PERFORMED? 2 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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK OR 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 STATE	
21. I attended the deceased from 12/8/31 , to 3-20-58 and last saw her alive on 3-18-58 Death occurred at 3:40 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Signature or title)		22b. ADDRESS 634 North Grand, St. Louis 3, Mo.	
22c. DATE SIGNED 3/21/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE MAR. 22. 1958	
23c. NAME OF CEMETERY OR CREMATORY ST. PETERS CATH. CEM.		23d. LOCATION (City, town, or county) (State) ST. CHARLES Mo.	
24. FUNERAL DIRECTOR P. L. Prinster ADDRESS St. Charles Mo.		25. DATE RECD. BY LOCAL REG. 3-21-58	
26. REGISTRAR'S SIGNATURE Herbert R. Donke M.D.			

PRINSTER-HUGHES

(Licensed Embalmer's Statement on Reverse Side)

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 *V E Morris*

Licensed Embalmer No. *3360*
P. O. Address *St Louis,*

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.