

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027821  
STATE FILE NUMBER

FILED JUL 21 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1878

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300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lemay</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Lemay 4870</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>Mary Ridge Nursing</b> INSTITUTION <b>Home 9353 S. Broadway</b>		Length of stay in lb <b>3 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>337 Goetz ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Elizabeth Koehler</b>			4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1958</b>		
First	Middle		Last		

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1, 1878</b>	9. AGE (In years and birthday) <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Oxford, Iowa</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Unknown Buerkner</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>August H.</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>496-36-1436</b>	17. INFORMANT <b>William E. Koehler</b> Address <b>339 Goetz ave. Lemay Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Chronic Myocarditis</b>	<b>5 yrs</b>
	DUE TO (c) <b>Chronic Nephritis</b>	<b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>f322</b>		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <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 STATE
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21. I attended the deceased from <b>10-15-57</b> to <b>July 14, 1958</b> and last saw her alive on <b>11<sup>th</sup> July 7-14-58</b> Death occurred at <b>2:10 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>John C. Crawford D.O. 2</b>	22b. ADDRESS <b>9612 S. Paulg</b>	22c. DATE SIGNED <b>7-15-58</b>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 17, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olive Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>3700 Mt. Olive Road Lemay 23, Mo.</b>
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24. FUNERAL DIRECTOR <b>C. Hollmeister Mortuaries</b> 7814 S. Broadway	25. DATE RECD. BY LOCAL REG. <b>7-15-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert P. Orourke M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

MEDICAL CERTIFICATION

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 *Lewis C. Hoffmeister* .....

Licensed Embalmer No. *3871* .....

P. O. Address *7814 S. Broadway* .....

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.