

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044869

STATE FILE NUMBER

FILED DEC 17 1958 Registration District No. 200 Primary Registration District No. 5740 Registrar's No. 126

300
1-57

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lingo Twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN New Cambria 0610 0
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION S. City limits		Length of stay in lb 11yrs.	d. STREET ADDRESS (If outside, give location) S. City limits
3. NAME OF DECEASED (Type or print) First Middle Last Francis William Koeppe			4. DATE OF DEATH Month Day Year Dec. 4, 1958
5. SEX M.	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 Jan. 15, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE (In years last birthday) 82 IF UNDER 1 YEAR Months Days 10 19 IF UNDER 24 HRS. Hours Min.
11a. FATHER'S NAME Gustave Koeppe		11b. MOTHER'S MAIDEN NAME Catherine	11. BIRTHPLACE (City and state or country) Stockton, Iowa
13a. FATHER'S NAME Gustave Koeppe		13b. MOTHER'S MAIDEN NAME Catherine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. 479 12 4412	
17. INFORMANT Mrs. Edna Pearl Koeppe, New Cambria, Mo		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic Cardiovascular disease DUE TO (c) Angina Pectoris for about 5 yrs.			INTERVAL BETWEEN ONSET AND DEATH
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.) 4201	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) George J. Ryan		22b. ADDRESS Marceline Missouri	22c. DATE SIGNED 12-6-58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Dec. 7, 1958	23c. NAME OF CEMETERY OR CREMATORY New Cambria	23d. LOCATION (City, town, or county) (State) New Cambria, Mo.
24. FUNERAL DIRECTOR F. J. Killand		25. DATE RECD. BY LOCAL REG. 12/10/58	26. REGISTRAR'S SIGNATURE Paul McNeely

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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JAN 7 1959

JAN 30 1959

Date Filed 12-73

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 H. J. Gilliland

Licensed Embalmer No. 4019

P. O. Address New Canaan, 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.