

FEDERAL BUREAU OF INVESTIGATION
 FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033986

FILED VS. SEP 22 1959

2 8413

STATE FILE NUMBER

ENDED 9/24/59 76 73 9
 DOCUMENT Marriage License application
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF Informant

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 11 yrs.		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 5367 Geraldine Ave.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5367 Geraldine Ave.			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First William Middle H. Last Koehler			4. DATE OF DEATH Month 9 Day 9 Year 59						
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/25/86	9. AGE (last birthday) 73 76	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman - Ret.		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (City and state or country) Nashville, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Phillip Koehler			13b. MOTHER'S MAIDEN NAME Mary unknown		14. NAME OF HUSBAND OR WIFE Myrtle Koehler				
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. 489-03-8839		17. INFORMANT Address Mrs. Myrtle Koehler, 5367 Geraldine					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1) Acute Pulmonary Edema Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 2) Arteriosclerotic Heart Disease 3) Pericardial Effusion DUE TO (b) 1.0 year DUE TO (c) 2 year						INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200						PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 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
21. I attended the deceased from 9/18/59 to 9/18/59 and last saw him alive on 9/5/59 Death occurred at 4:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) William N. Block M.D.				22b. ADDRESS 14 N. Taylor Ave			22c. DATE SIGNED 9/10/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 9/12/59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis		23e. STATE Mo.			
24. FUNERAL DIRECTOR Drehmann-Harral			ADDRESS 1905 Union	25. DATE RECD. BY LOCAL REG. SEP 11 '59	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.				

1511
Jr. 3-8600
Hrs. til 1 PM Thurs.
after 1 PM Fri.

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 Warren A. Carver

Licensed Embalmer No. 353

P. O. Address _____

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.