

**FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE**

**U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-037770**

**FILED VS OCT 19 1959**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2-8661**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>5 Hrs</b>	c. CITY OR TOWN <b>Berkeley</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4716 Kyle Ave.</b>
e. STATE <b>Missouri</b>		b. COUNTY <b>St. Louis</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Mark</b> Middle <b>Kochler</b> Last <b>Kochler</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>19</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-19-59</b>	9. AGE (last birthday)	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Donald Koehler</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Jane Wurtz</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Donald Koehler</b>	Address <b>4716 Kyle Ave.</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:		INTERVAL BETWEEN ONSET AND DEATH <b>5 HR.</b>
IMMEDIATE CAUSE (a) <b>Prematurity -</b>		
DUE TO (b) <b>Premature Sep. of Placenta</b>		
DUE TO (c) <b>Pregnancy -</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.) <b>761.5</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 <b>Born 9/19/57</b> to <b>9/19/59</b> and last saw her/him alive on <b>9/19/59</b> Death occurred at <b>9/19/59</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>[Signature]</i>	(Degree or title) <b>J. M.D.</b>	22b. ADDRESS <b>Wright City, Missouri</b>	22c. DATE SIGNED <b>9/21/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-22-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wright City Cemetery</b>	23d. LOCATION (City, town, or county) <b>Wright City, Missouri</b>

24. FUNERAL DIRECTOR <b>White-Mullen 118 N. Florissant Rd.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>SEP 21 1959</b>	26. PREPARER'S SIGNATURE <b>Earl Smith. M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**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 No Embalming, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed White-Mullen Mortuary Inc.  
  
Licensed Embalmer No. \_\_\_\_\_

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.