URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH 59-042101

FILED VS NOV 16 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 9776 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY	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 St. Louis — Length of stay in 1b 11 days	c. CITY OR TOWN Florissant — Inside Limits Yes # No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital — Inside Limits Yes # No ☐	d. STREET ADDRESS (If outside, give location) #9 Locust Dr. — Reside on Farm Yes ☐ No #

3. NAME OF DECEASED (Type or print)	First Emil	Middle	Last Koeppen	4. DATE OF DEATH Month Oct. Day 23, Year 1959
5. SEX Male	6. COLOR OR RACE White	7. Married ☐ Never Married ☐ Widowed # Divorced ☐	8. DATE OF BIRTH 7-6-1870	9. AGE (last birthday) 89 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) Germany	12. CITIZEN OF WHAT COUNTRY U. S.	
13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Mathilda Koeppen		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —	16. SOCIAL SECURITY NO. 488-18-1695	17. INFORMANT Avis Stein, Address Florissant, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Incarcerated Rt Inguinal Hernia — INTERVAL BETWEEN ONSET AND DEATH 2 wks

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____

DUE TO (c) 561.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis, Generalized

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑ — 20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 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 1955, to 10/23/59 and last saw her/him alive on 10/20/59

Death occurred at 9 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M. Bishop MD	22b. ADDRESS Florissant Mo	22c. DATE SIGNED 10/23/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/26/59	23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS White-Mullen Mortuary, Ferguson, Mo.	25. DATE RECD. BY LOCAL REG. OCT 26 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

VS NOV 18 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Reinhold K. Lohman

Signature of Student Embalmer

Licensed Embalmer No. 3395

P. O. Address St Louis 3

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.