

FEDERAL BUREAU OF INVESTIGATION  
 U.S. DEPARTMENT OF JUSTICE  
 BUREAU OF VITAL STATISTICS  
 NATIONAL BUREAU OF HEALTH STATISTICS  
 NATIONAL CENTER FOR HEALTH STATISTICS  
 NATIONAL CENTER FOR VITAL STATISTICS  
 NATIONAL CENTER FOR NATURAL STATISTICS  
 NATIONAL CENTER FOR STATISTICS

-60-007366

STATE FILE NUMBER

FILED VS MAR 14 1960

Registration District No. 234 Primary Registration District No. 4349 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>MORGAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MORGAN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>STOVER</u> OR TOWN		Length of stay in 1b <u>3 MONTHS</u>	c. CITY OR TOWN <u>STOVER</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 ND. ST. STOVER MO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2 ND. ST. STOVER MO.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>FRANCIS</u> Middle <u>WM.</u> Last <u>KOEHLER</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>8</u> Year <u>1960</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 30 1902</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RECEIVING CLERK</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>	11. BIRTHPLACE (City and state or country) <u>CLEVELAND OHIO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>WM. KOEHLER</u>	13b. MOTHER'S MAIDEN NAME <u>KATHERINE WEIS</u>	14. NAME OF HUSBAND OR WIFE <u>VIOLA KOEHLER</u>
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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) <u>YES WORLDWART</u>	16. SOCIAL SECURITY NO. <u>500-20-0606</u>	17. INFORMANT <u>VIOLA KOEHLER</u> Address <u>STOVER MO.</u>
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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
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>		<u>Minutes</u>
DUE TO (b) <u>Coronary Occlusion</u>		
DUE TO (c) <u>Arteriosclerosis</u>		

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
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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 _____ 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 _____
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21. I attended the deceased from MAR 8, 1960 to \_\_\_\_\_ and last saw her/him alive on MAR 8, 1960  
 Death occurred at 3:15 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Howard M. Keffa D.D.</u> (Degree, or title)	22b. ADDRESS <u>Stover, Mo</u>	22c. DATE SIGNED <u>3/10/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MARCH 11 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>STOVER CEMETERY</u>	23d. LOCATION (City, town, or county) <u>STOVER MO.</u> (State)
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24. FUNERAL DIRECTOR <u>J. H. Swinson</u> ADDRESS <u>Stover Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Mar. 12 1960</u>	26. REGISTRAR'S SIGNATURE <u>Tom L. Rippeger</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 9 700.

STATEMENT BY LICENSED EMBALMER

MAR 13 1969

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

*J. L. Stevenson*

Licensed Embalmer No.

4673

P. O. Address

*Stover N*

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.