

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041557

FILED VS NOV 21 1960

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 245 STATE FILE NUMBER

INDEXED

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Franklin</u> | | 2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u> | | Length of stay in 1b <u>10 yrs.</u> | c. CITY OR TOWN <u>Washington</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>426 MacArthur</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|--|----------------------------------|---|---|----------------------------------|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>George F. Koelkebeck</u> | | | 4. DATE OF DEATH Month Day Year <u>Nov. 15, 1960</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/20/1897</u> | 9. AGE (last birthday) <u>63</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |

| | | | |
|---|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Yard Cases, Missouri</u> | 11. BIRTHPLACE (City and state or country) <u>U. S. A.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> |
| 13a. FATHER'S NAME <u>Fred Koelkebeck</u> | 13b. MOTHER'S MAIDEN NAME <u>Katherine Schlake</u> | 14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/> | |

| | | |
|---|---|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>493-01-6080</u> | 17. INFORMANT Address <u>Mrs. Albert Freie, Washington, Mo</u> |
|---|---|---|

| | | |
|---|--|--|
| 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>Pneumonia</u> | | <u>3 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Bleeding from duodenal ulcer</u> | <u>2 weeks</u> |
| | DUE TO (c) <u>Arteriosclerotic Heart Disease</u> | <u>20+ yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u> | | 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 July 1960 to Nov. 15, 1960 and last saw him alive on Nov. 15, 1960
Death occurred at 9:05 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|--|--------------------------------------|-------------------------------------|
| 22a. SIGNATURE (Degree or title) <u>John B. Ryan M.D.</u> | 22b. ADDRESS <u>Washington Mo</u> | 22c. DATE SIGNED <u>11-16-60</u> |
|--|--------------------------------------|-------------------------------------|

| | | | |
|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Nov. 18, 1960</u> | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Washington, Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Neuberg & Witt, Inc. Washington, Mo.</u> | 25. DATE RECD. LOCAL REG. <u>11/17/60</u> | 26. REGISTRAR'S SIGNATURE <u>J.P. Huberman</u> | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 30 1960

JAN 6 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lester H. Witt

Licensed Embalmer No. 3254

P. O. Address Washington,

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.