

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-045326

FILED VS JAN 3 1961

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 343

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Osage</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		Length of stay in 1b <b>32 years</b>	c. CITY OR TOWN <b>Folk</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital No. 1</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Koehne</b> Last <b>Koehne</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>29,</b> Year <b>1960</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>7-23-1897</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>St. Elizabeth, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Casper Koehne</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Werchar</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) <b>unk</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>State Hospital No. 1 Fulton, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain - Thalamus (?) Cerebrovascular accident</b> DUE TO (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Stomach &amp; Duodenum - acute bleeding peptic ulcers</b>					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 checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year						
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 <b>State Hospital No. 1</b>		COUNTY <b>Folk, Mo</b>
21. <input checked="" type="checkbox"/> attended the deceased from _____ to _____	22. Death occurred at <b>5:25 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Deceased or title) <b>William J. Favicelli, M.D.</b>			22b. ADDRESS <b>Fulton, Mo.</b>		22c. DATE SIGNED <b>12-29-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>12/31/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Anthony</b>		23d. LOCATION (City, town, or county) (State) <b>Folk, Mo</b>		
24. FUNERAL DIRECTOR <b>Josephine G. Koehne</b>		ADDRESS <b>J.C. Koehne</b>	25. DATE RECD. BY LOCAL REG. <b>Dec. 29-1960</b>	26. REGISTRAR'S SIGNATURE <b>Maretha Lawrence</b>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_

*Signature of Embalmer*

Licensed Embalmer No. 4321

P. O. Address Jefferson Ave

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