

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020623

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **518E**

FILED JUN 7 1962

VS 300
Rev. 4/59

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DATE AMENDED
6/28/62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF
Unknown

13a, b Adolph Koebel & Mary

BY AFFIDAVIT OF Informant

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. City Hospital				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6421 Colletta Dr.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) FRED W. KOEBEL			First Middle Last			4. DATE OF DEATH May 21 1962			Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-4-1878		9. AGE (last birthday) 84		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (25 yrs.) - Weisert				10b. KIND OF BUSINESS OR INDUSTRY Tobacco Co.				11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Unknown Adolph Koebel				13b. MOTHER'S MAIDEN NAME Unknown Mary				14. NAME OF HUSBAND OR WIFE Late Elizabeth Koebel				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None				16. SOCIAL SECURITY NO.		17. INFORMANT Address Lydia P. Weber 1140 Dougherty Ferry Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning; Chronic Myocarditis; suffered when found in bath tub in home at 6421 Colletta Dr., on May 21st - 1962. Whether accidental or suicidal could not be determined DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) OPEN VERDICT 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										INTERVAL BETWEEN ONSET AND DEATH		
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"/> OPEN VERDICT		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) See above								
20c. TIME OF INJURY Hour a.m. p.m. 5-21-62		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE		
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE (Degree or title) Paul J. Simon Deputy Coroner						22b. ADDRESS 1308 Clark			22c. DATE SIGNED 5/22/62			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)				
Burial		May 24, 1962		New St. Marcus Cemetery		St. Louis, Mo.						
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.						25. DATE RECD. BY LOCAL REG. MAY 22 1962		26. REGISTRAR'S SIGNATURE Loan Smith. M.D.				

USE BLACK INK OR TYPEWRITER RIBBON

91

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 _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James R. Dennis

Licensed Embalmer No. 4527

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.

For information concerning this form, contact the State Board of Health, Department of Health, State Capitol Building, Raleigh, N.C.