

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-049172
STATE FILE NUMBER

Registration District No. 319 Primary Registration District No. 4469 Registrar's No. 69

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 7 1963

VS 300
Rev. 4/59

1 0951
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12 90-0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>ST. GENEVIEVE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. GENEVIEVE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. GENEVIEVE</u> Length of stay in 1b <u>50 YRS</u>		c. CITY OR TOWN <u>ST. GENEVIEVE</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>523 AUDUBON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>523 AUDUBON</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TERENICA</u> Middle <u>KOLLER</u> Last <u>KOLLER</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>62</u>
5. SEX <u>FEMALE</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>1/25/34</u>
9. AGE (last birthday) <u>78</u>		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) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>LAWRENCTOWN MO</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>LEOPOLD KOLLER</u>	
13b. MOTHER'S MAIDEN NAME <u>THERESA SCHWISSE</u>		14. NAME OF HUSBAND OR WIFE <u>FRANK KOLLER</u>	
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.	17. INFORMANT Address <u>Angene Koller St. Genevieve 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>ATHEROSCLEROTIC HEART DISEASE</u>			<u>4 YEARS</u>
DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>			<u>50 YEARS</u>
DUE TO (c) <u>DIABETES MELLITUS</u>			<u>20 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ 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	COUNTY _____ STATE _____
21. I attended the deceased from <u>4-22-60</u> to <u>12-28-62</u> and last saw her ^{her} _{him} alive on <u>12-27-62</u> Death occurred at <u>2 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>G. H. De Genova MD</u>		22b. ADDRESS <u>St. Genevieve, Mo</u>	22c. DATE SIGNED <u>12-28-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12/31/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALLESPRING</u>	23d. LOCATION (City, town, or county) (State) <u>ST. GENEVIEVE MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Lee C. Beebe St. Genevieve Mo</u>	25. DATE RECD. BY LOCAL REG. <u>29 December 1962</u>	26. REGISTRAR'S SIGNATURE <u>George F. Wood</u>	

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

Adrian J. Miller

Licensed Embalmer No.

4740

P. O. Address

St. Benedict, Mo

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.