

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-000199

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 31 Primary Registration District No. 5108 Registrar's No. \_\_\_\_\_

FILED JAN 29 1963	
1. PLACE OF DEATH a. COUNTY <b>BENTON</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WILLIAMS TOWNSHIP</b> Length of stay in 1b <b>LIFE</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3 Mi. S. Cole Camp</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>BENTON</b> c. CITY OR TOWN <b>COLE CAMP</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>3 Mi. S. Cole Camp</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GESENA</b> Middle <b>MARIA</b> Last <b>KOELLER</b>	
4. DATE OF DEATH Month <b>JAN.</b> Day <b>19</b> Year <b>1963</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-20-1872</b>
9. AGE (last birthday) <b>90 YRS.</b> 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) <b>HOUSE WIFE</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEKEEPING</b>	
11. BIRTHPLACE (City and state or country) <b>Cole Camp, MO</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>PETER KOHRS</b>	
13b. MOTHER'S MAIDEN NAME <b>LOUISA HAUSCHILD</b>	
14. NAME OF HUSBAND OR WIFE <b>JOHN H. KOELLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT Address <b>RT 3 FERDINAND BOETTJER COLE CAMP, 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>Medullary Paralysis</b> DUE TO (b) <b>Pulmonary Edema &amp; Consolidation</b> DUE TO (c) <b>Pneumonia, Lobar, bilateral</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Asthma -</b> 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 checked="" 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 <b>1-10-63</b> , to <b>1-19-63</b> and last saw her/him alive on <b>1-19-63</b> Death occurred at <b>1:08 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>Arturo Gonzalez</b>	
22b. ADDRESS <b>Cole Camp Mo.</b>	
22c. DATE SIGNED <b>1-22-63</b>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>BURIAL</b>	
23b. DATE <b>1-22-1963</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MONSEES CEMETERY</b>	
23d. LOCATION (City, town, or county) (State) <b>BENTON CO. MO</b>	
24. FUNERAL DIRECTOR ADDRESS <b>CHARLES FOX COLE CAMP</b>	
25. DATE RECD. BY LOCAL REG. <b>1-22-63</b>	
26. REGISTRAR'S SIGNATURE <b>E. J. Eckhoff</b>	

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

DATE AMENDED

20080

20080

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9490X

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

EMERALD STATE

**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

*Charles F. Fox*

Licensed Embalmer No.

4610

P. O. Address

PO Box CAMP, 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.