

FILED SEP 12 1968

DEPARTMENT OF PUBLIC HEALTH AND WELFARE - MISSOURI DIVISION OF HEALTH
(PHYSICIAN OR CORONER)

STATE FILE NUMBER

124

68 0034549
8267

CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

DECEASED—NAME		FIRST	MIDDLE	LAST	SEX	DATE OF DEATH (MONTH, DAY, YEAR)		
1. Margaret				Koester	Female	August 30 1968		
RACE WHITE, NEGRO, AMERICAN INDIAN, ETC. (SPECIFY)		AGE—LAST BIRTHDAY (YEARS)	UNDER 1 YEAR	UNDER 1 DAY	DATE OF BIRTH (MONTH, DAY, YEAR)		COUNTY OF DEATH	
4. White		94	MO. DAYS	HO. MIN.	Sept. 2, 1873		7a. —	
CITY, TOWN, OR LOCATION OF DEATH				INSIDE CITY LIMITS (SPECIFY YES OR NO)	HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER)			
7a. St. Louis				Inside	7b. Bethesda General Hospital			
STATE OF BIRTH (IF NOT IN U.S.A., NAME)			CITIZEN OF WHAT COUNTRY		MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY)		SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME)	
8. Waterloo, Ill.			U S A		10. Widowed		11. —	
SOCIAL SECURITY NUMBER				USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED)		KIND OF BUSINESS OF INDUSTRY		
12. 488-09-0394D				13a. Housewife		13b. own home		
RESIDENCE—STATE		COUNTY	CITY, TOWN, OR LOCATION		INSIDE CITY LIMITS (SPECIFY YES OR NO)		STREET AND NUMBER	
14a. Missouri		14b. St. Louis	14c. Shrewsbury		14d. inside		42 St. Charles Pl.	
FATHER—NAME			FIRST	MIDDLE	LAST	MOTHER—MAIDEN NAME		
15. Friederick O. Schulze						16. Barbara Emmenegger		
INFORMANT—NAME				MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)				
17a. Mrs. Leola Shrewsbury				17b. 42 St. Charles Pl. Shrewsbury, Mo. 63119				
PART I. DEATH WAS CAUSED BY:		[ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)]					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. IMMEDIATE CAUSE								
(a)		Bronchial pneumonia					48 hrs.	
DUE TO, OR AS A CONSEQUENCE OF:								
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST		(b) Arteriosclerotic heart disease					Chronic	
DUE TO, OR AS A CONSEQUENCE OF:								
(c)		General Arteriosclerosis					Chronic	
PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a)						AUTOPSY (YES OR NO)		
						19a. No		
ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY)		DATE OF INJURY (MONTH, DAY, YEAR)		HOUR		HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18)		
20a.		20b.		20c.		20d.		
INJURY AT WORK (SPECIFY YES OR NO)		PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY)		LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE)				
20a.		20b.		20c.		20d.		
CERTIFICATION—PHYSICIAN:			MONTH DAY YEAR		MONTH DAY YEAR		AND LAST SAW HIM/HER ALIVE ON	
21a. I ATTENDED THE DECEASED FROM			July 20, 1961		21b. Aug. 30, 1968		21c. Aug. 30, 1968	
CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED.			HOUR OF DEATH		THE DECEDENT WAS PROMULGED DEAD		DEATH OCCURRED AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED.	
22a.			4:55 P.		M. 20b. Aug. 30, 1968		21d. Not	
CERTIFIER—NAME (TYPE OR PRINT)			SIGNATURE		TITLE OR F.T.E.		DATE SIGNED (MONTH, DAY, YEAR)	
23a. Dr. O. D. Seabaugh, M.D.			[Signature]		M.D.		23c. Aug. 31, 1968	
MAILING ADDRESS—CERTIFIER			STREET OR R.F.D. NO.		CITY OR TOWN		STATE ZIP	
23a.			131 W. LOCKWOOD		WEBSTER GROVES, MO.		63119	
BURIAL, CREMATION, REMOVAL (SPECIFY)		CEMETERY OR CREMATORY—NAME			LOCATION			
24a. Removal		24b. Sunset Burial Parl			24c. St. Louis County, Mo.			
DATE (MONTH, DAY, YEAR)		FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)						
24a. Sept. 2 1968		Mittelberg-Berthel (Berthel) Mader, Webster Groves, Mo.						
FUNERAL DIRECTOR—SIGNATURE		REGISTERED PROFESSIONAL PREPARATOR—SIGNATURE		DATE RECEIVED BY LOCAL REGISTRAR				
25a. [Signature]		25b. [Signature]		25c. AUG 31 1968				

DO NOT WRITE ON THIS STUB

VS 300
Rev. 1/68

9. 1
10a. 94
10b.
11. 1
12. 2
13. 412-3
14. 4
15. 4
16.
17.
18. 0
19. CREDITS
20.

DECEASED

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

4040 →

PARENTS

CAUSE

CERTIFIER

BU

Type or print in
PERMANENT BLACK INK.
See handbook for instructions.

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 Paul R. Mcarty

Licensed Embalmer No. 4852

P. O. Address Webster Groves, 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.