Form No. 2
10M—2-43
5-17-39
I X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18248

FILED MAY 19 1944

Registration District No. 15   Primary Registration District No. 5572   Registrar's No. 51

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Rural Prarie [illegible] (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson County E. Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days (Specify whether years, months or days)
In this community 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 528 Ash. Fairmount Sta. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Francis Louise Koch
3. (b) If veteran, name war ✓
3. (c) Social Security No. None

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Wi
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive ... years
7. Birth date of deceased March (Month) 27 (Day) 1869 (Year)

8. AGE: Years 75, Months 0, Days 27. If less than one day ... hr. ... min.

9. Birthplace Warren County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name Herman Meistermann
13. Birthplace Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Bernadein Neighorhouse
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant William H Koch
(b) Address 528 N Ash, K.C. Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-26-1944 (Month) (Day) (Year)
(c) Place: burial or cremation West Glasco, Missouri
18. (a) Signature of funeral director George C. Carson
(b) Address Independence Mo
19. (a) April 26, 1944 (Date received local registrar) (b) F. M. Schick By Effie Schick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23 year 1944 hour 1 minute 10 A.M.

21. I hereby certify that I attended the deceased from April 14th, 1944, to 4-23, 1944
that I last saw her alive on 4-23, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death. Chronic Myocarditis	7
Acute Illness	10 da
Due to Fracture rt hip	10 da
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence 4-14-44
(c) Where did injury occur? Fairmount (City or town) Jackson (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? At home (Specify type of place)
While at work? no (e) Means of injury fall

23. Signature [illegible] (M.D. or other) M.D.
Address Kansas City   Date signed 4/24/44

1162

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAY 1 8 1948

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..., Registered Apprentice No..., working under my personal supervision.

Signed Floyd C. Carson

Licensed Embalmer No. 4199

P. O. Address Independence

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 this body is not embalmed, fact should be so stated above.

S. No. 2B
DM—5-43
I X36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Temp

Registration District No. 150 | Primary Registration District No. | Registrar's No. 51

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Rural Prairie Twp (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Francis L. Koch
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 27 (Day) (Year)
8. AGE: Years 75 Months 0 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Retired Widow
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) T. M. Schuler Dep. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 23 year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

18248