MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

22360

1. PLACE OF DEATH
County Crawford — Registration District No. 229
Township Boone — Primary Registration District No. 5211
City Bourbon, Mo. (No. ..... St. ..... Ward)

File No. .....
Registered No. .....

2. FULL NAME John Koch
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 36 yrs. 4 mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Husband

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 5-10-1865

7. AGE: Years 65 | Months 2 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer 463
(b) General nature of industry, business, or establishment in which employed (or employer): 46
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) France

PARENTS
10. NAME OF FATHER: Louis Koch
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) France
12. MAIDEN NAME OF MOTHER: Paulina Bauer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) France

14. INFORMANT: Mrs Bertha Dora Koch
(Address) Bourbon, Mo.

15. FILED 7-20, 1930 C. W. Adams, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-17- 1930

17. I HEREBY CERTIFY, That I attended deceased from July - 7 - 1930, to July - 17 - 1930, that I last saw him alive on July - 9 - 1930, and that death occurred, on the date stated above, at 1:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinomia of Stomach and Bowels
(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 4 4 W
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
0 DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Jas. P. Dunnigan, M. D
, 19 (Address) Sullivan Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Hardy Cemetery
DATE OF BURIAL: 7/19/ 1930

20. UNDERTAKER: E E Long
ADDRESS: Bourbon, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.