

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

Do not use this space.

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1. PLACE OF DEATH
 County Benton Registration District No. 61 File No. _____
 Township Tom Primary Registration District No. 5096 Registered No. 21
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Mrs Rachel Kooch
 (a) Residence No. London Ohio St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Bennett C. Kooch

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 29, 1846

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>85</u>	<u>2</u>	<u>15</u>	

8. OCCUPATION OF DECEASED None

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Hancock County, Illinois
 (STATE OR COUNTRY) Illinois

10. NAME OF FATHER Gas Rice Green

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Elizabeth Green

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dond Knaut
 (STATE OR COUNTRY) Ill.

14. INFORMANT Effie Belle Kooch
 (Address) London Ohio

15. FILED 1-15-32 Geo A Logue REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 14, 1932

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1932 to Jan 14, 1932, and that I last saw her alive on Jan 13, 1932, and that death occurred, on the date stated above, at 2:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral
94A
162 (duration) yrs. 7 mos. 7 da.
 CONTRIBUTORY Senile decay
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? (3)

WHAT TEST CONFIRMED DIAGNOSIS.
 (Signed) Ed Lindsey M.D.
 , 19 (Address) Warsaw 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 Bertrand Mo DATE OF BURIAL Jan 15, 1932

20. UNDERTAKER 6 Miller ADDRESS Warsaw 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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Benton
Township Town
City _____ (No. _____ St. _____ Ward)

Registration District No. 61
Primary Registration District No. 3096

File No. _____
Registered No. 2

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19__

19. UNDERTAKER (ADDRESS)

20. FILED 1/15/32 Jas A Logan Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 14, 1932

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19__

I last saw him alive on _____, 19__. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Argentina
Virginia Pecton's
Other contributory causes of importance
Senile decay

Date of onset

Name of operation _____ Date of _____

What test confirmed diagnosis _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19__

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

N. B. -- Every item of information should be supplied. AGE should be supplied in plain terms, so that it may be properly classified. EXACTLY. PHYSICIANS should state the cause of DEATH in plain terms, so that it may be properly classified. EXACTLY. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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