

MOV 9

1939

## MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

36013

Do not use this space.

## 1. PLACE OF DEATH

(a) County Franklin Registration District No. 297  
 (b) Township Washington Primary Registration District No. 3016  
 or Washington (d) Street No. St Francis Hospital St.  
 (c) City Washington (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 47 yrs. — mos. 10 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 88

## 2. PRINT FULL NAME

THEKLA HELENA KOCH  
 (a) Residence, No. Marthasville, Mo. St.  Marthasville, Mo.  
 (Usual place of abode, if no street address, write county or city) (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)  
married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 16 1892

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
47 9 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) Sept 1939 11. Total time (years) spent in this occupation 47

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

FATHER 13. NAME Gustav ~~John~~ Ahman

14. BIRTHPLACE (CITY OR TOWN) Marthasville 0  
(STATE OR COUNTRY) Mo. 0

MOTHER 15. MAIDEN NAME Caroline Hildebrand 0

16. BIRTHPLACE (CITY OR TOWN) Marthasville 0  
(STATE OR COUNTRY) Missouri 0

17. INFORMANT Emmet Koch  
(ADDRESS) Marthasville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Marthasville Mo DATE Oct 16 1939

19. FUNERAL DIRECTOR (NAME) Fred W. Schumaker  
(ADDRESS) Marthasville

20. FILED Oct. 13 1939 J. D. Mayhew  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 13, 1939

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1935, to Oct 13, 1939

I last saw her alive on Oct 13, 1939. Death is said to have occurred on the date stated above, at 7:45 a.m.

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

Partial  
Obstructed  
Obstruction Terminal  
Ileum  
Date of onset 1 week

Other contributory causes of importance:

Acute myocarditis 1 day

Name of operation Raparotomy Date of Oct 4 39

What test confirmed diagnosis clinical Was there an autopsy? No.

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) Nurbert H. Schumaker, M. D.

(Address) Marthasville, Mo.

1222

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 Fred W. Lightenbury

Licensed Embalmer No. 1321

P. O. Address Wartlesville 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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

36013

Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 297  
 (b) Township Washington Primary Registration District No. 3016  
 (c) City Washington (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 88

2. PRINT FULL NAME

Thekla Helena Koch  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>7</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)			
7. AGE	YEARS <u>47</u>	MONTHS <u>9</u>	DAYS <u>28</u>
			If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		
	9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)			
20. FILED _____ 19__			

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 13 1937

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_ 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:

Partial Intestinal obstruction Terminal adenocarcinoma of the sigmoid with adhesions after hysterectomy Date of onset \_\_\_\_\_

Other contributory causes of importance: acute myo Carditis

Name of operation Laparotomy Date of \_\_\_\_\_ 1937

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) Herbert H Schmidt, M. D.  
 (Address) \_\_\_\_\_

Local Registrar.

SUPPLEMENT

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. F. I. S. C. N. S. should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY L.C.M.

V. S. 25.  
50M-8-37  
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