

FILED FEB 12 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH1784
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 86
 (b) Townshp Washington Primary Registration District No. 5127
 or
 (c) City (d) Street No. R.F.D. #1 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 50 yrs. 0 mos. 1 ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Mrs. Christina F. Koch
 (a) Residence, No. F.F.I. #1 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>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Charles F. Koch</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>August 14, 1849</u>		
7. AGE	YEARS	MONTHS
	<u>90</u>	<u>5</u>
		DAYS
		<u>1</u>
		If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>	
	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) <u>January 9, 1940</u>	
	11. Total time (years) spent in this occupation <u>60 yrs.</u>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Lockport, New York.</u>		
FATHER	13. NAME <u>George Whitman</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>(unk) Germany</u>	
MOTHER	15. MAIDEN NAME <u>Christina Renz</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>(UNK) Germany</u>	
17. INFORMANT (ADDRESS) <u>Robert L. Koch R.F.D. #1, St. Joseph, Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>ashland Cemetery</u> DATE <u>Jan. 18, 1940</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>E. R. Sidenfaden F. Home 602 South 10th Street</u>		
20. FILED <u>Jan 16, 1940</u> <u>H. J. Nestelbreck</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 15, 1940

22. I HEREBY CERTIFY, That I attended deceased from May 11, 1936, to Jan. 15, 1940

I last saw her alive on Jan. 15, 1940. Death is said to have occurred on the date stated above, at 1:48 P.M.

The principal cause of death and related causes of importance were as follows:
Chronic hypocardial Insufficiency Date of onset unknown

Other contributory causes of importance:
Arteriosclerosis General

Name of operation none Date of

What test confirmed diagnosis clinical Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no 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? no
 If so, specify

(Signed) Walter H. Law M. D.
 (Address) 1114 North 10th St. St. Joseph, Mo

(Licensed Embalmer's Statement on Reverse Side)

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. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X 16605

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, & by

Mollie E. Sidenfaden

, Registered Apprentice No. 145

working under my personal supervision.

Signed

R. V. West

Licensed Embalmer No. 3876

P. O. Address St. Joseph 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.