No. 2
1-10-30
-17-39
X21492

FILED

DE[illegible] OF COMMERCE
THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24831

Registration District No. 1941/71

Primary Registration District No. 4100

Registrar's No. 22

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

1. PLACE OF DEATH:

(a) County Chariton

(b) City or town Keytesville (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Bridge Street (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Chariton 1021

(c) City or town Keytesville (If outside city or town limits, write "RURAL")

(d) Street No. Bridge St (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME DR. CHARLES D. KOCH

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mattie Koch

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased April (Month) 14 (Day) 1849 (Year)

8. AGE:

Years	Months	Days	If less than one day
92	3	15	hr. min.

9. Birthplace Clinton (City, town, or county) La (State or foreign country)

10. Usual occupation M. D. Retired

11. Industry or business M. D.

FATHER
12. Name Geard Koch
13. Birthplace (City, town, or county) 4 Germany (State or foreign country)

MOTHER
14. Maiden name Josephine Uhlman
15. Birthplace (City, town, or county) 4 Germany (State or foreign country)

16. (a) Informant P. D. A. Duncan

(b) Address Keytesville

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31 (Month) 1941 (Day) (Year)

(c) Place: burial or cremation Marian (Marysville)

18. (a) Signature of funeral director Hyde & Garrett

(b) Address Keytesville Mo

19. (a) 7/30/41 (Date received local registrar) (b) Mrs Roy G. Landrie (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month July day 29 year 1941 hour 3 minute 30 M.

21. I hereby certify that I attended the deceased from Sept 17, 1938, to July 29, 1941, that I last saw him alive on July 29, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic pneumonia	1 day
Due to Senility	
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 Carl C. Weger (M. D. ~~or other~~) D

Address Keytesville, Mo Date signed 7/30/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number 8-(8-41)
Date Filed

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 H. O. Barnett

Licensed Embalmer No. 3046

P. O. Address Kaytesville 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.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24831

Registration District No. 171 Primary Registration District No. 4100 Registrar's No. 22

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

Verbally per mo.

1. PLACE OF DEATH:
(a) County Christian
(b) City or town Reynolds
(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 (Specify whether years, months or days)
In this community

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 Dr. Charles D. Koch
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 29 year 1941 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.

Immediate cause of death	Duration
Hypostatic pneumonia (Lobar)	da
Due to Senility	
Due to	
Other conditions (Include pregnancy within 3 months of death) 108	
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)
(b) 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

5-24831