

FILED JUN 8 1943

Registration District No. 171

Primary Registration District No. 4266

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Wellington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community. (Yes or No)
years, months or days)

3. (a) PRINT FULL NAME OTTO - KOCH

3. (b) If veteran, no name war no
3. (c) Social Security No. none

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Lidia 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased May 24 1867
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>11</u>	<u>3</u>	hr. min.

9. Birthplace Augusta Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Miller

11. Industry or business Miller

12. Name Gustav Koch

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lidia Koch

(b) Address Wellington Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-29-43
(Month) (Day) (Year)

(c) Place: burial or cremation Wellington Mo.

18. (a) Signature of funeral director Even Funeral Home

(b) Address Wellington Mo.

19. (a) May 31-43 (Date received local registrar) (b) Mrs. W. Baker (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lafayette
(c) City or town Wellington
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 27 day April
year 1943 hour 4 minute A.M.

21. I hereby certify that I attended the deceased from June 15 1942 to Apr 27 1943
that I last saw him alive on Apr 20 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac exhaustion Duration 3 mo.

Due to

Due to

Other conditions Acemisson Anta 72
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature W. P. Baker (M. D. or other) Address Wellington Mo. Date signed 7/28/43

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

MOTHER FATHER

1157

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 6-7-43

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 W. P. Emen

Licensed Embalmer No. 4305

P. O. Address Wellington 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 171

Primary Registration District No. 4266

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Willington
(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)

In this community _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette

(c) City or town Willington
(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 Utto 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 Hyde 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased May 24 - 1872
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 3 If less than one day min.

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

10. Usual occupation _____

11. Industry of business _____

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) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death cardiac extension

Due to _____

Due to _____

Other conditions Coronary aorta
(Include only if within 3 months of death)
new tumor

Major findings: Of operations _____

Of autopsy _____

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)

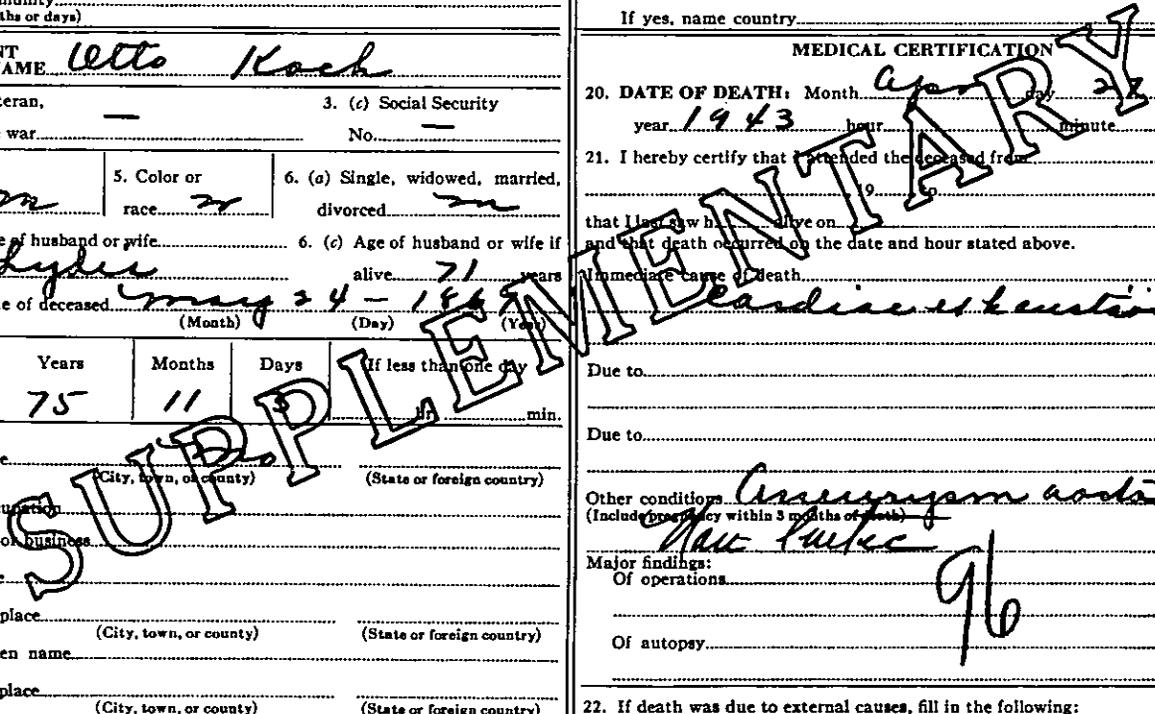
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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



S-18233