No. 2
1—2-43
5-17-39
I X356

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32556

FILED SEP 25 1943

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 2095

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
D. O. A. St. Louis Co. Hospital
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin

(c) City or town Washington 031
(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 Herbert Henry Koch

3. (b) If veteran, name war World War # 2

3. (c) Social Security No. .....

4. Sex Male 0

5. Color or race ~~Male~~ W

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

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

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

7. Birth date of deceased Dec 1 1915
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
27	9	14	hr. min.

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

10. Usual occupation Soldier

11. Industry or business U. S. Army

FATHER
12. Name August Koch
13. Birthplace Washington Mo
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Maire Schroeder
15. Birthplace Washington Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Evelyn Koch
(b) Address Washington Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-43 (Month) (Day) (Year)
(c) Place: burial or cremation Washington, Mo.,

18. (a) Signature of funeral director Nieberg & Vitt Unc. Co
(b) Address Washington, Mo.,

19. (a) SEP 20 1943 (Date received local registrar) (b) E. G. McGovern MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 15
year 1943 hour 2:55 minute A 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 Multiple Fractures of Skull, Frc of Lt. Upper Arm & Rt. Upper Leg. Crushing Injury

Due to to the Chest, First Second & third Degree Burns of Head, Trunk

Due to & Extremities

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....

Of autopsy Yes

Duration

170e-6

22

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) Accidnet 096

(b) Date of occurrence Sept 15, 1943

(c) Where did injury occur? Hy # 66 West of Eureka
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place.
(Specify type of place)

While at work? ..... (e) Means of injury 2 car collision

23. Signature William G. Bernhard MC (M. D. or other)
Address Station Hosp. Jeff. Bks Mo Date signed 9-18-43

(Licensed Embalmer's Statement on Reverse Side)

APR 10 1944

MAR 11 1951

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.....

Licensed Embalmer No.....

P. O. Address.....

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.