

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18248**
Registrar's No. **51**

FILED MAY 19 1944
Registration District No. **158**

Primary Registration District No. **5572**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Rural Prairie**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Jackson County E. Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days**
In this community **12 yrs.**
years, months or days

3. (a) PRINT FULL NAME

Francis Louise Koch
3. (b) If veteran, name war **✓**
3. (c) Social Security No. **1-2-22**

4. Sex **female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **91**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **27** years
7. Birth date of deceased **March 27 1869**
(Month) (Day) (Year)

8. AGE: Years **75** Months **0** Days **27**
If less than one day hr. min.

9. Birthplace **Warren County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name **Herman Meistermann**
13. Birthplace **Germany** (City, town, or county) (State or foreign country)
14. Maiden name **Bernadine Neightorhouse**
15. Birthplace **Germany** (City, town, or county) (State or foreign country)

16. (a) Informant **William H. Koch**
(b) Address **528 N. Ash, K.C. Mo.**
17. (a) **Removal** (Burial, cremation, or removal)
(b) Date thereof **4-26-1944** (Month) (Day) (Year)
(c) Place: burial or cremation **West Glaseo Missouri**

18. (a) Signature of funeral director **George C. Carson**
(b) Address **Independence Mo**
19. (a) **April 26, 1944** (Date received local registrar)
(b) **F. M. Schick** (Registered signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **528 Ash Fairmount Sta.**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **23**
year **1944** hour **1** minute **10** A.M.

21. I hereby certify that I attended the deceased from **April 14** 19**44** to **4-23** 19**44**
that I last saw him alive on **4-23** 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic Myocarditis**
Coronary Atherosclerosis
Due to **fracture of hip**

Due to **1560 a**
Other conditions: **10**
(Include pregnancy within 3 months of death)

Major findings: **10**
Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **accident**
(b) Date of occurrence **4-14-44**
(c) Where did injury occur? **Fairmount Jackson Mo** (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home

While at work? **no** (Specify type of place)
(e) Manner of injury **fall**
23. Signature **W. H. Schick** (M. D. or other)
Address **Independence** Date signed **4/24/44**

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

MAY 18 1948

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.

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. *Tung*
 Registrar's No. *51*

Registration District No. *150*

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Jackson*
 (b) City or town *Rural Prairie Tung*
 (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 _____
 years, months or days)

3. (a) PRINT FULL NAME *Francis J. Koch*

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *F* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *w*

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

7. Birth date of deceased *march 27* (Month) (Day) (Year)

8. AGE: Years *75* Months *0* Days _____ If less than one day _____ min.

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

10. Usual occupation *retired widow*

11. Industry or 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 _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) *F. M. Schieffelin* (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *April* 23
 year *1944* hour _____ minute _____ M.

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

Duration

Due to _____

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?

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

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

Address _____ Date signed _____

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

SUPPLEMENTARY

18248