

FILED NOV 23 1945
318

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Isolation Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Day**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5800 Arsenal St.**
(If rural, give location) _____
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **HENRY P. KOCH**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, widower **Divorced Widower**

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

7. Birth date of deceased **February 17 1865**
(Month) (Day) (Year)

8. AGE: Years **80** Months **8** Days **24** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Nil**

11. Industry or business _____

12. Name **Unknown**

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

14. Maiden name **Catherine, ?**

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

16. (a) Informant **City Infirmary Records**

(b) Address **5800 Arsenal St.**

17. (a) **Removal** (b) Date thereof **11-12-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Athens, Ill.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **NOV 14 1945** (b) **J. J. Bredsek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **10**
year **1945** hour **3:00** minute _____ P.M.

21. I hereby certify that I attended the deceased from **Nov 18, 1945**
to **NOV. 10 1945**
that I last saw him alive on **November 10 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death
Hypertensive Cardio-vascular disease
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Duration _____

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)
(c) Means of injury _____
23. Signature **Julius E. Helin** (M. D. or other) **M.D.**
Address **5800 Arsenal St.** Date signed _____

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

MOTHER FATHER

0986

0986

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 John Agnoski
Licensed Embalmer No. 3398
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.