No. 2
-2-43
17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED NOV 17 1945

State File No. 36968

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 241

1. PLACE OF DEATH:

(a) County Cole

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

(c) Name of hospital or institution: 620 Broadway
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 50 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole

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

(d) Street No. 620 Broadway
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Rose Louise Kocher

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Alex

6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased March 25 1864
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
81	7	11	hr. min.

9. Birthplace California, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name August Schliecker
13. Birthplace unk (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unk
15. Birthplace Unk (City, town, or county) 9 (State or foreign country)

16. (a) Informant Alex Kocher

(b) Address Jefferson City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-45 (Month) (Day) (Year)

(c) Place: burial or cremation California, Mo. Cemetery

18. (a) Signature of funeral director Victor Buescher

(b) Address Jefferson City, Mo.

19. (a) 11-8-45 (Date received local registrar) (b) R. P. Dorris MD (Registrar's signature) MR

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 6
year 45 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from 9/24/45, 19__, to 11/6, 1945
that I last saw her alive on 11/6, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis, hypertension	1 yr.
Due to: Hypertension	?
Due to:	
Other conditions: Fracture left hip (Include pregnancy within 3 months of death)	6 wk.

Major findings:
Of operations .....
Of autopsy .....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 [signature] (M. D. or other) MD

Address Jefferson City, Mo. Date signed 11/8/45

1431

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No.
District File Number
Date Filed 11-14-45

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 Victor Buescher

Licensed Embalmer No. 3701

P. O. Address Jefferson City, 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.

. No. 2B
1—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 266

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 241

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City
(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 Rose L. Kocher

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Mar 25 1864
(Month) (Day) (Year)

8. AGE: Years 81 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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 Nov Day 16 year 1945 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

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) Accident

(b) Date of occurrence 9/24/45.

(c) Where did injury occur? Jefferson City Cole Mo
(City or town) (County) (State)

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

While at work? Yes (e) Means of injury A fall to the floor

23. Signature Edward Cowles M.D. (M. D. or other)

Address Jefferson City Mo Date signed 11/20/45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Nov 16

369068