. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 19 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31879

Registration District No. 224 — Primary Registration District No. 5796 — Registrar's No. 58

1. PLACE OF DEATH:
(a) County: Monitean Co.
(b) City or town: Rural (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: Missouri (b) County: Monitean
(c) City or town: Rural (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 .....

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3. (a) PRINT FULL NAME: EMMA KOCHER
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Fred Kocher
6. (c) Age of husband or wife if alive: 85 years
7. Birth date of deceased: Feb (Month) 17 (Day) 1867 (Year)

8. AGE: Years 80 | Months 6 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace: Switzerland (City, town, or county) (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business .....
FATHER 12. Name: Cesar Aeschlimann
FATHER 13. Birthplace: Switzerland (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Don't know
MOTHER 15. Birthplace ..... (City, town, or county) (State or foreign country)
16. (a) Informant: Miss Bertha Kocher
(b) Address: California R.R. #1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-11-47 (Month) (Day) (Year)
(c) Place: burial or cremation: City Cem. California
18. (a) Signature of funeral director: Hugh E. Wellman
(b) Address: California Mo.
19. (a) 9/12/47 (Date received local registrar) (b) H R Porter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept day: 9 year: 1947 hour: 6 minute: 55 A.M.
21. I hereby certify that I attended the deceased from April 1, 1947, to Sept 9, 1947; that I last saw h. alive on Sept 9, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardio-Vascular Disease with Hypertension.	5 years
Due to:	
Due to:	
Other conditions: Cardiac Asthma (Include pregnancy within 3 months of death)	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause of 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: Edgar A. Kibbe (M. D., ~~or other~~)
Address: California Date signed: 9/11/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 9,
District File Number
Date Filed SEP 18 1947

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 Hugh E. Williams

Licensed Embalmer No. 3537

P. O. Address California 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.