

FILED DEC 16 1947

Registration District No. **376**

Primary Registration District No. **6075**

Registrar's No. **390**

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Farmington RURAL St. Francois  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri State Hospital No. 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 18 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME WALTER G. KOCH  
3. (b) If veteran, name war None 3. (c) Social Security No. 493 10 3882

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Berniece Bass 6. (c) Age of husband or wife if alive Age Unk years  
7. Birth date of deceased October 1 1897  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>		<u>28</u>	hr. min.

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

10. Usual occupation Salesman

11. Industry or business National Paper & Hotel Supply

12. Name Christ Koch

13. Birthplace Highland Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Zaccary

15. Birthplace Highland Illinois  
(City, town, or county) (State or foreign country)

16. (c) Informant Recrds: State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 10-31-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland, Illinois

18. (a) Signature of funeral director Tibbits & Co. Undertakers

(b) Address Highland, Illinois

19. (a) 12-10-47 (b) Ether Rudloff  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin  
(c) City or town Clarkton  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name, country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29  
year 1947 hour 6 minute 15 A.M.

21. I hereby certify that I attended the deceased from October 11 1947 to October 29 1947, that I last saw him alive on October 29 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Cerebral hemorrhage</u>	<u>4-5 hrs.</u>
Due to <u>Malignant hypertension and generalized arteriosclerosis</u>	<u>10 yrs.</u>

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy None

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 [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed 10/29/47

RECEIVED

Health Officer No. 4  
District File Number 1247-1562  
Date Filed 12-15-47

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 Paul H. Deziel

Licensed Embalmer No. 4120

P. O. Address Farmington 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.