

No. 30-10-47  
5-17-39  
I 3906

#76070  
FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED SEP 7 1948 318  
Registration District No. 318

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 74913  
7459  
Registrar's No.

Primary Registration District No.

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

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:  
St. Louis City Hospital 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution one year  
(Specify whether years, months or days)

In this community.....  
years, months or days

3. (a) PRINT FULL NAME ALBERT KOCH

3. (b) If veteran, name war.....

3. (c) Social Security No. ....

4. Sex Male 0 5. Color or race white

6. (a) Single, widowed, married, divorced, Divorced 3

6. (b) Name of husband or wife Jennie Koch

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

7. Birth date of deceased November 9 1890  
(Month) (Day) (Year)

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

67	9	16	hr. min.
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9. Birthplace Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business.....

MOTHER FATHER {

12. Name Henry M. Koch

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Schenken

15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Harriett Vennemann

(b) Address 425 Seekamp Kirkwood 22 Mo.

17. (a) Cremation (b) Date thereof 8/27/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Meyer-Pfitzinger

(b) Address Kirkwood 22 Mo

19. (a) AUG 26 1948 (b) J. J. Bredek  
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 600

(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL") 9

(d) Street No. 5076 Washington 0  
(If rural, give location)

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25th  
year 1948 hour 10 minute 05 A. M.

21. I hereby certify that I attended the deceased from 11/20/47  
19....., to Aug. 25th 19 48

that I last saw him alive on Aug. 25th 19 48  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral aneurysm of the upper 46  
sinus

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 James J. McDaniel 07  
1515 Lafayette 8/25/48  
Address Date signed

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**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 M. Ingle*

Licensed Embalmer No. *3288*

P. O. Address *Kirkwood 229*

**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.**