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47070

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

FILED NOV 6 1948

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution:
5220 Lisette /
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME Leo F Koch

3. (b) If veteran, name war _____

3. (c) Social Security No. 497-07-8082

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Sophie

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased May 18 1895
(Month) (Day) (Year)

8. AGE: Years 53 Months 5 Days 5 If less than one day hr. min.

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

10. Usual occupation Brewery Worker

11. Industry or business _____

12. Name Jacob Koch

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

14. Maiden name Mary Hund

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

16. (a) Informant Sophie Koch

(b) Address 5220 Lisette

17. (a) Burial (b) Date thereof 10/26/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Resurrection Cemetery

18. (a) Signature of funeral director John L Ziegenhein & Sons

(b) Address 7027 Gravois Ave.

19. (a) OCT 23 1948 (b) J. B. Parater
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County do

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

(d) Street No. 5220 Lisette
(2) (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23
year 1948 hour 8 minute 25 A.M.

21. I hereby certify that I attended the deceased from Oct. 17, 1948, to Oct. 23, 1948, that I last saw him alive on Oct. 23, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Typhoid or Paralytic Ileus

Due to or appendicitis

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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) (Means of injury)

23. Signature [Signature] (M. D. or other) _____

Address 2621 S. [Address] Date signed 10/23/48

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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..... *W. G. Peterson*

Licensed Embalmer No. *3767*

P. O. Address..... *7027 Grawsi*

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.