

FILED JUL 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21706**  
Registrar's No. **5519**

#87604

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

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

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>5519</b>			
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____						
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		OR TOWN <b>2019</b>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #41</b>			d. STREET ADDRESS (If rural, give location) <b>7625 Ivory</b> <b>0</b>						
3. NAME OF DECEASED (Type or Print) a. (First) <b>HERMAN</b>			b. (Middle) _____		c. (Last) <b>KOCH</b>		4. DATE OF DEATH <b>June 22nd, 1950</b> (Month) (Day) (Year)		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Mar. 6 1892</b>		9. AGE (In years last birthday) <b>58</b>	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Days _____	IF UNDER 24 HRS. Hours _____	IF UNDER 24 HRS. Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Koch Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME <b>Herman Koch</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Sylvia</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Sylvia Koch</b>					ADDRESS <b>7625 Ivory</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral metastasis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <del>Primary carcinoma</del> DUE TO (c) <b>Bronchogenic Carcinoma</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____		(COUNTY) _____		(STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>162X</b>					
22. I hereby certify that I attended the deceased from <b>6/19/50</b> , 19____, to <b>6/22/50</b> , 19____, that I last saw the deceased alive on <b>6/22/50</b> , 19____, and that death occurred at <b>12:50pm</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>L AUERMANN</b> (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>1515 Lafayette Ave.,</b>			23c. DATE SIGNED <b>6/22/50</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>6-26-1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		24d. LOCATION (City, town, or county) <b>St. Louis</b>		(State) <b>Mo.</b>		
DATE REC'D BY LOCAL REG. <b>JUN 26 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. Foster</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. P. Fendler Jr.</b>				ADDRESS <b>7128 Michigan</b>

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

Signed .....  
Student Embalmer

Licensed Embalmer No. 4093

P. O. Address St Louis

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.