S. No. 300
V. 10.48

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

FILED MAR 25 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8622

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 107

1. PLACE OF DEATH
a. COUNTY: Adair
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kirksville
c. LENGTH OF STAY (In this place): 7 days.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grim Smith Mem. Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Macon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elmer 0610
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Beulah
b. (Middle): Agnes
c. (Last): Koger

4. DATE OF DEATH (Month) (Day) (Year): Mar 11 1953

5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): M.
8. DATE OF BIRTH: Dec. 21, 1914
9. AGE (In years last birthday): 38 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Elmer 0
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Lewis Hoffman
13b. MOTHER'S MAIDEN NAME: Della Rosamah Still
14. NAME OF HUSBAND OR WIFE: Theodore Oscar Koger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Theodore Osaar Koger — ADDRESS: Elmer Mo

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of breast c̄ metastasis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12/24/52
19b. MAJOR FINDINGS OF OPERATION: 170 X
20. AUTOPSY? YES ☐ NO ☑

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) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 3-6, 1953, *to* 3-11, 1953 *that I last saw the deceased alive on* 3-11, 1953, *and that death occurred at* 7:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: George E. Gaim (Degree or title): M.D.
23b. ADDRESS: Kirksville Mo
23c. DATE SIGNED: 3/12/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Mar 14 1953
24c. NAME OF CEMETERY OR CREMATORY: Bunce
24d. LOCATION (City, town, or county) (State): Macon Mo

DATE REC'D BY LOCAL REG.: 3-17-53
REGISTRAR'S SIGNATURE: Tate Lambert
25. FUNERAL DIRECTOR'S SIGNATURE: W H McCollum — ADDRESS: South Gifford Mo

(Licensed Embalmer's Statement on Reverse Side)

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 .....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed W. H. McCollum

Licensed Embalmer No. 2052

P. O. Address South Gifford 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.