

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27801

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 925

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	c. LENGTH OF STAY (In this place) <u>60 Yrs</u>	c. CITY OR TOWN <u>St. Joseph</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1312 Olive St.,</u>		e. STREET ADDRESS (If rural, give location) <u>1312 Olive St.,</u> <u>0117</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Della</u> b. (Middle) <u>T</u> c. (Last) <u>Koch</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 20, 1953</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 6, 1872</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Maryville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Samuel H. Townsend</u>	13b. MOTHER'S MAIDEN NAME <u>Catherine Hess</u>	14. NAME OF HUSBAND OR WIFE <u>John W. Koch</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>John W. Koch</u>	ADDRESS <u>1312 Olive St. Joseph</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pyloric Obstruction & Intention</u>		3 mos.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Gastro-duodenal Carcinoma</u>		
DUE TO (c) <u>Multiple duodenal ulcers & recurring hemorrhage</u>		✓	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>General Arteriosclerosis</u>		years	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>151X</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Dec. 7, 1943, to Aug. 20, 1953, that I last saw the deceased alive on Aug. 20, 1953, and that death occurred at 10 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>E. D. Schindler, D.O.</u>	23b. ADDRESS <u>421 Shubert Bldg., Kansas City, Mo.</u>	23c. DATE SIGNED <u>Aug. 20-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-23-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Miriam Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Maryville, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Aug 29, 1953</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Herman W. Sidenfaden</u>	ADDRESS <u>1802 Union St. Joseph, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

3.300
0.48

FILED AUG 31 1953

8961 87 10N

NOV 13 1953

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..... Signature of Student Embalmer

Signed *Robert H. Gable*

Licensed Embalmer No..... 3300

P. O. Address St. Joseph.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.