

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33551

State File No.

FILED OCT 15 1953

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 9111

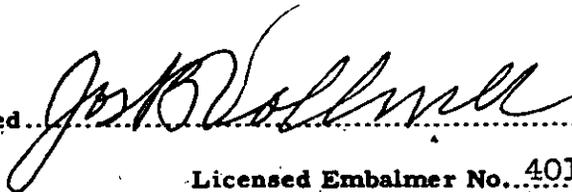
BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</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>3851 McRee</u>				e. STREET ADDRESS (If rural, give location) <u>17 3851 McRee 2790</u>			
3. NAME OF DECEASED (Type or Print) <u>LEONA KOCH</u>			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 19 1953</u>	
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>Mar 25 1892</u>	
9. AGE (In years last birthday) <u>61</u>		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) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Firtle Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>John Whaley</u>			13b. MOTHER'S MAIDEN NAME <u>Delia DeClue</u>		14. NAME OF HUSBAND OR WIFE <u>Reuben Koch</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Reuben Koch 3851 McRee</u> ADDRESS _____		
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) <u>Cerebral Thromboses</u> INTERVAL BETWEEN ONSET AND DEATH <u>Suddenly</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Artery Disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>					
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>					
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		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? <u>4201</u>			
22. I hereby certify that I attended the deceased from <u>9/14/53</u> 10:00, to <u>9/19</u> , 19 <u>53</u> that I last saw the deceased alive on <u>4/19</u> , 19 <u>53</u> and that death occurred at <u>1:00 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Preston C. Hall MD</u> (Degree or title) _____				23b. ADDRESS <u>3902a Lafayette</u>		23c. DATE SIGNED <u>9/21/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 22-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>		
DATE REC'D BY LOCAL REG. <u>SEP 21 1953</u>		REGISTRAR'S SIGNATURE <u>J. C. Smith MD</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Schnur</u> ADDRESS <u>3125 Lafayette</u>		

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

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 

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.