

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35945**  
**4853**

**70608**  
**WLED OCT 28 1953**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside of corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>46 min</u>		8150 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Mary's Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>4501 W. 53 Terrace</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Baby Boy</u> b. (Middle) <u>Koeppe</u> c. (Last) <u>Koeppe</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9-22-53</u>		
5. SEX <u>Male</u>		6. COLOR OF RACE <u>white</u>		7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>new born</u>	
8. DATE OF BIRTH <u>9-22-'53</u>		9. AGE (In years last birthday) <u>-</u>		IF UNDER 1 YEAR Days <u>-</u>	
IF UNDER 24 HRS. Hours <u>-</u> Mins. <u>46</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		

13a. FATHER'S NAME <u>Hester John Koeppe</u>		13b. MOTHER'S MAIDEN NAME <u>Leahelle Ann Pratt</u>		14. NAME OF HUSBAND OR WIFE _____	
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 ADDRESS <u>Mrs. Lester Koeppe 4501 W. 53 Terrace</u>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature birth</u>		INTERVAL BETWEEN ONSET AND DEATH <u>46 min</u>	
		ANTECEDENT CAUSES 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.		<u>776X</u>	

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? _____	

22. I hereby certify that I attended the deceased from 9/22/53, 1953, to 9/22/53, 1953, that I last saw the deceased alive on 9/22/53, 1953 and that death occurred at 9:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>E. J. Schulte</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>5015 Linden, Kansas</u>		23c. DATE SIGNED <u>9.23.53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>retained</u>		24b. DATE <u>9-22-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Hospital</u>	
		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>			

DATE REC'D BY LOCAL REG. <u>10-9-53</u>		REGISTRAR'S SIGNATURE <u>Blondine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>St. Mary's Hospital Kansas City, Mo.</u>	
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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 .....  
Student Embalmer

Signed.....

Licensed Embalmer No. \_\_\_\_\_

P. O. Address: \_\_\_\_\_

**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.