

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **34328**

FILED OCT 20 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **277** PRIMARY REG. DIST. NO. **4712** Registrar's No. **37**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Pike</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Pike</b>	
b. CITY OR TOWN <b>Curryville</b>	c. LENGTH OF STAY (in this place) <b>2 yrs</b>	c. CITY OR TOWN <b>Curryville</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3 mi SE Curryville</b>		e. STREET ADDRESS (If rural, give location) <b>3 mi SE Curryville</b>	

<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>HARRY</b> b. (Middle) <b>HAROLD</b> c. (Last) <b>KODER</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Oct 9 1955</b>		
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<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>married</b>	<b>8. DATE OF BIRTH</b> <b>Oct 29 1887</b>	<b>9. AGE</b> (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>10</b>	IF UNDER 24 HRS. Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Millwright</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> -----		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) / <b>Des Moines Iowa</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>US</b>	
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<b>13a. FATHER'S NAME</b> <b>John Koder</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Sarah Gladson</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Clara Koder</b>	
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>	(If yes, give war or dates of service)	<b>16. SOCIAL SECURITY NO.</b> <b>488 09 0131</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <b>Clara Koder, Curryville, Mo.</b>		
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)		<b>MEDICAL CERTIFICATION</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>30 Months</b>
<p><i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i></p>		<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Crown Aneurysm</b>			
		<b>ANTECEDENT CAUSES</b>			
		<p>Morbid conditions, (if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p align="right">DUE TO (b) _____</p> <p align="right">DUE TO (c) _____</p>			
		<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <b>4201</b>			

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP)</b> (COUNTY) (STATE)
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
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**22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased dead on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> (Degree or title) <b>J. M. Mathews M.D.</b>		<b>23b. ADDRESS</b> <b>Bowling Green Mo.</b>	<b>23c. DATE SIGNED</b> <b>10-11-55</b>
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>24b. DATE</b> <b>Oct. 12 55</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>W.C.M. Curryville</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>Curryville Mo.</b>
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<b>DATE REC'D BY LOCAL REG.</b> <b>10-14-55</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Geo. Robinson</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. H. Hudd</b>	<b>ADDRESS</b> <b>Funeral Home, Bowling Green</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 10 1952

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 *James C. Mudd* .....  
Licensed Embalmer No. 415

P. O. Address *Bowling Green*

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.