

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40840**

FILED DEC 24 1956

BIRTH NO. _____ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 5182 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Shawnee</u>	c. LENGTH OF STAY (in this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>	d. STREET ADDRESS (If rural, give location) <u>Attenberg Star R Mo.</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Attenberg Star R.</u>		d. STREET ADDRESS <u>Attenberg Star R Mo.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Maria</u> b. (Middle) <u>Anne</u> c. (Last) <u>Koch</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 14 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 9 1897</u>	9. AGE (In years last birthday) <u>79</u> Months <u>2</u> Days <u>5</u> Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homeworks</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>New Wells Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Peter Weinberg</u>	13b. MOTHER'S MAIDEN NAME <u>Maria Holman</u>	14. NAME OF HUSBAND OR WIFE <u>Martin Koch</u>
15. WAS DECEASED EVER IN U.S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD (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 AND ADDRESS <u>Ervin Koch, Attenberg Star R.</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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		<u>2 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, General</u> DUE TO (c) _____		<u>7 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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., to or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>331x</u>
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 Dec. 30, 1952 to Dec. 14, 1956, that I last saw the deceased alive on Dec. 14, 1956, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Theodore Fisher M.D.</u>	23b. ADDRESS <u>Attenberg Mo</u>	23c. DATE SIGNED <u>12-15-56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec 16 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Wells</u>	24d. LOCATION (City, town, or county) (State) <u>New Wells Mo</u>
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DATE REC'D BY LOCAL REG. <u>12-18-56</u>	REGISTRAR'S SIGNATURE <u>T. C. Summers</u>	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>M. Combs 414 G Jackson Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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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 B A Meyer

Licensed Embalmer No. 305-1

P. O. Address Jackson 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.