

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1136

STATE FILE NUMBER

FILED JAN 22 1957

Registration District No. 139 Primary Registration District No. 4225 Registrar's No. 4

1. PLACE OF DEATH a. COUNTY <u>Holt</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Holt</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>OREGON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>OREGON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb <u>50 yrs</u>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES JACOB KOOCK</u>			4. DATE OF DEATH Month Day Year <u>JAN 10 1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u>	8. DATE OF BIRTH <u>Feb 27, 1871</u>	9. AGE (In years last birthday) <u>85</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>landscape</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gardner</u>	11. BIRTHPLACE (City and state or country) <u>SEDALIA, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Jacob Koock</u>			14. MOTHER'S MAIDEN NAME <u>BERRYMAN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>79-142997</u>	17. INFORMANT Address <u>Mrs Mildred Watkins</u> <u>409 E ARMOUR K.C. MO.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE, (a) <u>Myocarditis, Myocardosis</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>2-3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced crippling Osteoarthritis 4200</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> -NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Sept 15, 1954</u> to <u>Jan 10, 1957</u> and last saw <u>her</u> alive on <u>Jan 10, 1957</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. J. Sweeney</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>Oregon, Mo.</u>		22c. DATE SIGNED <u>1/12/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JAN 12, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>OREGON, Mo.</u>
24. FUNERAL DIRECTOR <u>James H. Pettigrew</u> Address <u>Oregon Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-14-1957</u>		26. REGISTRAR'S SIGNATURE <u>James H. Pettigrew</u>	

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms written as listed: All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

JAN 22 1951

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 H. Pittsford*

Licensed Embalmer No. 319

P. O. Address *Oregon*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.