

Health, Welfare, Public Service  
 300  
 1-56  
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 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

2884

FILED FEB 4 1957  
 1937 9-56

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 432

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JEFFERSON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ARNOLD</u>		0500 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>GLENNON MEMORIAL</u>		Length of stay in lb <u>6 DAYS</u>	d. STREET (If outside, give location) ADDRESS <u>Rt. 2 - Box 362</u>		29 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ARLANNA</u> Middle <u>SOPHIE</u> Last <u>KOCHNER</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>12</u> Year <u>1957</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 24 - 1956</u>	9. AGE (In years last birthday) <u>0</u> IF UNDER 1 YEAR Months <u>10</u> Days <u>21</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS, MO.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>ALPHONSE L. KOCHNER</u>		
14. MOTHER'S MAIDEN NAME <u>ANNA MEYER</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>		
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT (Address) <u>MR ALPHONSE KOCHNER Rt. 2, ARNOLD, MO 7716</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>Probable Amyotonia Congenita</u> <u>Probable amyotonia, congenita</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Aspiration of mucus</u> DUE TO (c) <u>Aspiration of mucus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1-6-57</u> <u>1-12-57</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>744-1</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 <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>					
20d. INJURY OCCURRED WHILE AT <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>1/6/57</u> to <u>1/12/57</u> and last saw her alive on <u>1/12/57</u> Death occurred at <u>7:30 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Robt. A. Korn</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>8230 Forsythe</u>		22c. DATE SIGNED <u>1-15-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JAN-16-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>IMMACULATE CONCEPTION CH. ARNOLD, MO</u>		23d. LOCATION (City, town, or county) (State) <u>ARNOLD, MO</u>
24. FUNERAL DIRECTOR <u>FEY FUNERAL Home, MEHLVILLE MO.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 15 '57</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

**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 *Gustav W. Dutcher*  
.....

Licensed Embalmer No. *42*

P. O. Address *St. Louis*

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.