

STATE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29659

STATE FILE NUMBER

FILED AUG 26 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7057

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Length of stay in lb 2	d. STREET ADDRESS (If outside, give location) 5604 Neosho St.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ERNEST OTTO KOOS			4. DATE OF DEATH Month Day Year July 28 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1880	9. AGE (In years last birthday) 76 IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber-Self Employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Davenport, Iowa	
13. FATHER'S NAME Henry J. W. Koos			14. MOTHER'S MAIDEN NAME Maria Geertz		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT Address Lillian VanTassel 4954 West Pine	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse carcinomatosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Bronchogenic carcinoma DUE TO (c) 1.62x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH 6 months 18 "
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 3-21-56 to 7-28-57 and last saw ^{her} him alive on 7-28-57 Death occurred at 5:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) David M. Skilling Jr. M.D.			22b. ADDRESS 18 South Kingshighway		22c. DATE SIGNED 7-29-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Rail)		23b. DATE 7-30-1957	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Davenport, Iowa
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway			25. DATE RECD. BY LOCAL REG. JUL 29 57	26. REGISTRAR'S SIGNATURE Carl Smith M.D.	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me; or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Richard W. Storrson*

Licensed Embalmer No. *46*

P. O. Address.....

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.