

X No. 300  
10.48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30504

State File No. ....

FILED AUG 26 1957

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

BIRTH NO. _____		REG. DIST. NO. <u>324</u>		PRIMARY REG. DIST. NO. <u>3072</u>		Registrar's No. <u>159</u>	
1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY OR TOWN <u>Marshall</u>		c. LENGTH OF STAY (In this place) <u>1/2 hr</u>		c. CITY OR TOWN <u>Marshall</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>360 S. Odell</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JESSE</u> b. (Middle) <u>EDMUND</u> c. (Last) <u>KOPPENBRINK</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 17, 1957</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 10, 1881</u>		9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager &amp; Hotel Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store &amp; Hotel</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Concordia Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Peter H. Koppenbrink</u>		13b. MOTHER'S MAIDEN NAME <u>Matilda Newhaus</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel H. Koppenbrink</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>500-22-8829</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Mabel H Koppenbrink Marshall Mo</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Killed in car accident</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hit by car, while crossing street</u> DUE TO (c) <u>crossing street</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>20 Min</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <u>+</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <u>S. Odell Ave Marshall</u>		21c. (CITY, TOWN, OR TOWNSHIP) <u>Marshall</u> (COUNTY) <u>Saline</u> (STATE) <u>Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Aug-17-57 8:20 p.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Hit by Car, while crossing street</u>			
22. I hereby certify that I attended the deceased from <u>5-45 p.m.</u> to <u>8:20 p.m.</u> , 19 <u>57</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>8:20 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>C. L. Lawless M.D. Coroner Saline Co.</u> (Degree or title) <u>3</u>			23b. ADDRESS <u>Marshall Mo</u>			23c. DATE SIGNED <u>8-19-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-20-1957</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Higgenessville Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Higgenessville Mo</u>		
DATE REC'D BY LOCAL REG. <u>8-19-57</u>		REGISTRAR'S SIGNATURE <u>Cecil H. Reed</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Harry Hershberger Marshall, Mo</u>			

SEP 3 1957

MAR 31 1956

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..... *Harry Herschberger*

Licensed Embalmer No. *435*

P. O. Address *Marshall,*

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.