

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038969

STATE FILE NUMBER

FILED NOV 17 1958 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1209

300
1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hospital		d. STREET ADDRESS 1710 Colhoun Street	
Length of stay in lb Lifetime		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Robert L. Koch			4. DATE OF DEATH Month Day Year November 8, 1958.		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1892.	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer	10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (City and state or country) St. Joseph, Missouri.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Charles Koch	13b. MOTHER'S MAIDEN NAME Christine F. Wiedman	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. none	17. INFORMANT Harry J. Koch	Address St. Joseph, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 4 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Atherosclerosis		
DUE TO (c) Terminal pneumonia		?

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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.)
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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
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21. I attended the deceased from 11-5-58 to 11-8-58 and last saw him alive on 11-8-58 Death occurred at 11:05 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Doctor or title) Dr. John L. Motherhead	22b. ADDRESS 2603 Fredrick	22c. DATE SIGNED 11-10-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 11, 1958.	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri.
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24. FUNERAL DIRECTOR Incehoff, Salem, Mo. by [Signature]	25. DATE RECD. BY LOCAL REG. Nov. 11, 1958	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Dr. John L. Motherhead

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 *Albert C. Harrington*

Licensed Embalmer No. 3258

P. O. Address St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.