

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046758

STATE FILE NUMBER

FILED DEC 30 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3282

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</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 <u>Robert Koch Hospital</u>		Length of stay in lb <u>9 days</u>		4. STREET ADDRESS (If outside, give location) <u>23 2735 So. Broadway</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kate</u> Middle <u>Decker</u> Last <u>Decker</u>				4. DATE OF DEATH Month <u>December</u> , Day <u>14</u> , Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-17-70</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Jake Decker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Martin</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>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Records of Robert Koch Hospital</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>Obstructive emphysema with chronic bronchitis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>? YRS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Emphysema</u>	DUE TO (c) <u>502,0</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>Arteriosclerotic heart disease, generalized arteriosclerosis, malnutrition, fracture of right os calcaneus.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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>6:00 p.m.</u> Month, Day, Year							
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>12-5-58</u> to <u>12-14-58</u> and last saw her <sup>her</sup> <del>her</del> alive on <u>12-14-58</u> Death occurred at <u>6:00 p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Harold G. Russell M.D.</u>				22b. ADDRESS <u>Robt. Koch Hosp., Koch, Mo.</u>		22c. DATE SIGNED <u>12-15-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/16/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Missouri</u>			
24. FUNERAL DIRECTOR <u>Jos. W. Clark F.H. 1125 Hodiamont</u>			ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12-15-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert P. Dondel M.D.</u>		

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service  
300-1-56  
ATTORNEY GENERAL'S OFFICE  
No symptoms will be 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

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 *Alfred J. Bredes*.....  
Licensed Embalmer No. *26*

P. O. Address *1125 H...*

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.