

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007908

STATE FILE NUMBER

11 FEB 24 1959 Registration District No. 317 Primary Registration District No. 546 Registrar's No. 422

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>ST LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Overland</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Overland 4008</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2104 Brown Rd</b> Length of stay in 1b <b>YRS</b>		d. STREET ADDRESS (If outside, give location) <b>2104 Brown</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>MARJORIE</b> Middle <b>A.</b> Last <b>KOCH</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>12th</b> Year <b>1959</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 7, 1910</b>	9. AGE (In years last birthday) <b>49</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>dental assistant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>dentistry</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Dr. William E. Koch</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Kraft</b>	14. NAME OF HUSBAND OR WIFE <b>single</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>496-30-8499</b>	17. INFORMANT Address <b>Dr. Wm. E. Koch Jr., 509 Sunnyside</b>
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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) <b>Respiratory failure from metastatic tumor to cervical spine - medulla</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 Mo</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Primary carcinoma of kidney</b> DUE TO (c) _____	<b>8 Mo</b>	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>180X</b>	

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 _____ 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 <b>5.15.58</b> to <b>death</b> and last saw her alive on <b>2.9.59</b> Death occurred at <b>3:00 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Charles H. Judson M.D.</b> (Degree or title)	22b. ADDRESS <b>3720 Washington Ave</b>	22c. DATE SIGNED <b>2.13.59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>Feb 15, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Augusta (Local)</b>	23d. LOCATION (City, town, or county) (State) <b>Augusta Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>C.R. Lupton and sons 7233 Delmar Blvd</b>	25. DATE RECD. BY LOCAL REG. <b>2-13-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Muzley, M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

*Miss E. B. Green*

**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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*

P. O. Address *St. Louis, 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.