

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 14 1961

-61-003972

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 339

DATE AMENDED 2/21/61
 INSTEAD OF
 Pt. I Information was added see 18 b & c
 Pt. II Should have been left blank chronic cholecystitis, ventral hernia
 BY AFFIDAVIT OF attending physician
 MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>St. Louis</i> | | | | 2. USUAL RESIDENCE (Where deceased lived... if institution: residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Franklin</i> | | | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) <i>Kirkwood</i> | | Length of stay in lb <i>3 days</i> | | c. CITY OR TOWN <i>Zabadie</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Joseph's Hospital</i> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (if outside, give location) | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Cansadie C. Koch</i> | | | | 4. DATE OF DEATH Month Day Year <i>Feb. 1, 1961</i> | | | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>White</i> | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <i>1/5/1883</i> | |
| 9. AGE (last birthday) <i>78</i> | | IF UNDER 1 YEAR Months <i>0</i> Days <i>21</i> | | IF UNDER 24 HR Hours <i>0</i> Min. <i>0</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home Maker</i> | |
| 10a. USUAL OCCUPATION | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | | 11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo.</i> | | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i> | |
| 13a. FATHER'S NAME <i>William Caldwell</i> | | | 13b. MOTHER'S M maiden name <i>Sarah Couster</i> | | | 14. NAME OF HUSBAND, OR WIFE <i>Richard W. Koch</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT Address <i>Mr. Aug. Gilchrist, Washington, Mo</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis Superior Mesenteric Artery 6 hrs</i> <i>Operation for (1) chronic cholecystitis, (2) cholelithiasis</i> DUE TO (b) <i>Postoperative</i> DUE TO (c) <i>(3) Ventral hernia</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>CHRONIC CHOLECYSTITIS; VENTRAL HERNIA</i> | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 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 a.m. p.m. 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 <i>10 Jan 61</i> to <i>1 Feb 61</i> and last saw ^(her) him/alive on <i>1 Feb 61</i> Death occurred at <i>8:50 A.m</i> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>L. B. Brown M.D.</i> | | | | 22b. ADDRESS <i>10070 Euclid, St. Louis</i> | | 22c. DATE SIGNED <i>2 Feb 61</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Feb. 4, 1961</i> | | 23b. DATE <i>Feb. 4, 1961</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Bethel Cemetery</i> | | 23d. LOCATION (City, town or county) (State) <i>Washington, Mo.</i> | |
| 24. FUNERAL DIRECTOR <i>Nieburg & Witt, Inc. Washington, Mo</i> | | ADDRESS <i>2417 N. 1st St.</i> | | 25. DATE RECD. BY LOCAL REG. <i>2-6-61</i> | | 26. REGISTRAR'S SIGNATURE <i>John B. M... M.D.</i> | |



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

Lester H. Witt

Licensed Embalmer No. 3254

P. O. Address Washington, D.C.

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.