

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-016967

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

39773

STATE FILE NUMBER

DO NOT WRITE ON THIS STUDY

AMENDED

FILED APR 25 1962

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3449a Crittenden St.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MINNIE Middle W. Last KOCH			4. DATE OF DEATH Month Apr. Day 14 Year 1962								
5. SEX Female		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6-30-1906		9. AGE (last birthday) 55		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Louis Grimm				13b. MOTHER'S MAIDEN NAME Theresa Voninger				14. NAME OF HUSBAND OR WIFE Philip A. Koch			
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 Philip A. Koch		Address 3449a Crittenden St.			
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 1 week	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Essential Hypertension										5 years	
DUE TO (c) 4201											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								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 Oct 1955 to April 1962 and last saw her alive on April 14, 1962 Death occurred at 10 A m on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE Marion W. Doring MD (Degree or title)		22b. ADDRESS 539 N. Grand		22c. DATE SIGNED 4/15/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Apr. 17, 1962		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town, or county) St. Louis Co. Mo.		(State)			
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd. ADDRESS				25. DATE RECD. BY LOCAL REG. APR 16 1962		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.					

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

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2 **216**
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4 **1**
5 **1**
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74



Dr. Davis @ St. John's Hosp
10 A.M. Sunday

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 Ernest W. Spillars

Licensed Embalmer No. 4080

P. O. Address _____

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.