

DEPT APR 12 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

8320
Do not use this space.

791
1003

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No..... 2085
(c) or City..... St. Louis, Mo. (d) Street No. 5260 Davison St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Don Paul Koch, Sr.,

(a) Residence, No. 5260 Davison Ave., St. 7 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Goldie Koch,

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 1st, 1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 50 1 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Police Officer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

FATHER 13. NAME Freder ck Koch

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Dorothy Bischof

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Mrs. Goldie Koch, (ADDRESS) 5260 Davison Ave.,

18. BURIAL, CREMATION, OR REMOVAL PLACE Friedens Cem. DATE Mar. 6th 39

19. FUNERAL DIRECTOR (NAME) Henry Leidner Und. (ADDRESS) 1417 N. Market Street.

20. FILED MAR 4 1939 19 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 3rd, 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1939 to Mar. 3, 1939

I last saw him alive on Mar. 3, 1939. Death is said to have occurred on the date stated above, at 1:45 P.M.

The principal cause of death and related causes of importance were as follows:

Acute Myocarditis, caused by cholecystitis
126
Date of onset 3/1/39

Other contributory causes of importance: subacute Cholecystitis calculous 1wk? Chronic Bronchitis (Bronchoectasis) 10yrs?

Name of operation None Date of
What test confirmed diagnosis? Lab. Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? No Date of injury....., 19... Where did injury occur? No (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury No Nature of injury No

24. Was disease or injury in any way related to occupation of deceased? No If so, specify (Signee) M. D. (Address) 3547 Easton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Homer L. Ponder*

Licensed Embalmer No. *3367*

P. O. Address *2223 St Louis*

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 this body is not embalmed, above space should be left blank.