

FILED **MAR 29 1943**

Registration District No. **784**

Primary Registration District No. **780**

1. PLACE OF DEATH:

(a) County **St Louis**
(b) City or town **Koch**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Robert Koch Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 yr 9 mo 11 day**
In this community **15 year** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **COO**
(c) City or town **ST LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **4715 a WASH IN 70 N**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) **1**
If yes, name country **1**

3. (a) PRINT FULL NAME **PACHECO GENARO**

3. (b) If veteran, name war
3. (c) Social Security No. **488-16-6973**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **3** **Divorced**

6. (b) Name of husband or wife **Marie Pacheco** 6. (c) Age of husband or wife if alive, years **31**

7. Birth date of deceased **Sept 19 1882**
(Month) (Day) (Year)

8. AGE: Years **60** Months **6** Days **2** If less than one day hr. min.

9. Birthplace **LIMA PERU**
(City, town, or county) (State or foreign country)

10. Usual occupation **BAKER**

11. Industry or business

12. Name **John PACHECO**
13. Birthplace **Lima Peru**
(City, town, or county) (State or foreign country)
14. Maiden name **Elaine TARKES**
15. Birthplace **LIMA PERU**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hosp. Record**
(b) Address **Robert Koch Hospital**

17. (a) **Burial** (b) Date thereof **3-23-43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cem**

18. (a) Signature of funeral director **W. J. Ambrose**
(b) Address **6633 Clayton Ave**

19. (a) **3-23-45** (b) **Genaro Pacheco**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **21**
year **1943** hour **9** minute **30** P. M.

21. I hereby certify that I attended the deceased from **June 10 1941** to **March 21 1943**
that I last saw him alive on **March 21 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberculosis of Spine & Rt Hip** Duration **5 years**

Due to
Due to

Other conditions (Include pregnancy within 3 months of death) **16**

Major findings: Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (a) Means of injury

23. Signature **Frank Cohen** (M.D. or other)
Address **Robert Koch Hosp** Date signed **3/21/43**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

212
6/43

MAR 20 1943

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 Edward J. Bockhard
Licensed Embalmer No. 2502

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 this body is not embalmed, fact should be so stated above.