

No. 2
DM-5-43
v. 5-17-39
I X38671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29942**
Registrar's No. **3796**

FILED SEP 25 1948

Registration District No. **189** Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3816 BELLEFONTAINE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Months (Specify whether years, months or days)

In this community 6 Months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 3816 BELLEFONTAINE
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOSEPHINE L. KOCH

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased APRIL 1, 1864
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 12TH. year 1948 hour 11 minute 00 A. M.

21. I hereby certify that I attended the deceased from June 1948 to Sept 12, 1948
that I last saw her alive on Sept 10, 1948
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>5</u>	<u>11</u>	_____ hr. _____ min.

Immediate cause of death Hodgkin's Disease Duration 1 Yr.

Due to _____

Due to _____

9. Birthplace HUTCHISON, KANS.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

Other conditions Hypertensive Cardio-Vasc D 1 Yr.
(Include pregnancy within 6 months of death)

MOTHER FATHER

11. Industry or business _____

12. Name JOHN KOCH 4

13. Birthplace IRELAND
(City, town, or county) (State or foreign country)

14. Maiden name CATHERINE DOYNE 4

15. Birthplace IRELAND
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: Of operations None 4/1/5

Of autopsy None

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Wm Gibson

(b) Address 3816 Bellefontaine

17. (a) Removal (b) Date thereof 9-12-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LA SANCHEWARTH, KS

18. (a) Signature of funeral director Bill S... ..

(b) Address LEAVENWORTH, KANS.

19. (a) 9-16-48 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) None

(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) (e) Mearns _____

23. Signature [Signature] (M. D. or _____)
Address 217 E. 11th St. Bldg 1 R.P. Date signed 9/12/48

2 Mo

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 *Paul W. Sumpter*

Licensed Embalmer No. *3862- (P. O. Sumpter)*

P. O. Address *Lawrence, 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 this body is not embalmed, fact should be so stated above.

Body removed to Kansas Before embalming.