

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42670

State File No. _____
Registrar's No. 10672

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>10672</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis, Mo.</u>)		c. LENGTH OF STAY (In this place) <u>one day</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Barnes Hospital,</u>				d. STREET ADDRESS (If rural, give location) <u>W.K. 4655 Spring Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>Mary</u>		a. (First) _____		b. (Middle) <u>F</u>		c. (Last) <u>Koch</u>	
4. DATE OF DEATH <u>Dec. 11 1949</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>9-4-1925</u>		9. AGE (In years last birthday) <u>24</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>John Winingear</u>		13b. MOTHER'S MAIDEN NAME <u>Huegel</u>	
14. NAME OF HUSBAND OR WIFE <u>Carl H. Koch, Jr.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Carl H. Koch, Jr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>laryngeal obstruction</u>		ANTECEDENT CAUSES					
* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <u>Nephrotic syndrome</u>					
		DUE TO (c) <u>Diss. Lupus Erythematosus</u>					
II. OTHER SIGNIFICANT CONDITIONS		<u>lobar pneumonia - otitis media.</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) <u>890</u>			
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR _____		<u>3912</u>	
22. I hereby certify that I attended the deceased from <u>Dec. 11</u> , 19 <u>49</u> , to <u>Dec. 11</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Dec. 11</u> , 19 <u>49</u> , and that death occurred at <u>4:15 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>FR. Randall MD</u>				23b. ADDRESS <u>Barnes Hospital</u>		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-14-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>7801 Canasta Ave.</u>	
DATE REC'D BY LOCAL REG. <u>DEC 12 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Sarales</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Zeyenhein Bros.</u>		ADDRESS <u>6409 Gravois Ave</u>	

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

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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed *Bluro R. Padwell*.....

Signed.....
Student Embalmer

Licensed Embalmer No. *4079*.....

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.