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

Do not use this space.

32351

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 9766

City St Louis (No. 3119- Arsenal St. ..... Ward)

2. FULL NAME Andrew B Koenig

(a) Residence. No. 3119- Arsenal St., 16 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

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: Helen Koenig

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 18- 1867

7. AGE: Years 60 | Months — | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor Agency
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Illinois

PARENTS
10. NAME OF FATHER: Bernard Koenig
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

14. INFORMANT: Helen Koenig
(Address) 3119- Arsenal St

15. FILED NOV -1 1927, 19..... Mark Starkcoff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 27 1927

17. I HEREBY CERTIFY, That I attended deceased from 5-1 ....., 1927, to 10-27, 1927, that I last saw him alive on 10-25, 1927, and that death occurred, on the date stated above, at 6:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Valvular Heart disease
131
92A (duration) ..... yrs. 5 mos. 25 ds.

CONTRIBUTORY (SECONDARY): Chronic Nephritis (duration) ..... yrs. 5 mos. 25 ds.

129A

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
0 DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? X. Ray and Urinalysis
(Signed) Bert O. Owens, M.D.
10/29, 1927 (Address) 745 Missouri Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Sunset Burial Park
DATE OF BURIAL: Nov 1 1927

20. UNDERTAKER: Wacker-Helderle
ADDRESS: 2331 S Bdwy

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.

SUBMITTING THIS IS A PERMANENT RECORD