

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

Do not use this space.

38482

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. Josephine Hospital) St. _____ (Ward)

File No. _____
 Registered No. 11157

2. FULL NAME

(a) Residence. No. 2853 Eads Ave 23rd Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 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 Dorothea Koenig

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 20-1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 | 8 | 24

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Merchant Sailor
 (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) Germany

10. NAME OF FATHER B. 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 Dorothea Koenig
 (Address) 2853 Eads Ave

15. FILED 11 15 27 Max B. Starckoff REGISTERED

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 13 1927

17. I HEREBY CERTIFY, That I attended deceased from December 3, 1927 to Dec. 13, 1927 that I last saw him alive on Dec. 12, 1927, and that death occurred, on the date stated above, at 12:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
 (duration) yrs. mos. ds. 14
 CONTRIBUTORY (SECONDARY) 100%
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Geo. Krapf M. D.
Dec. 13, 1927 (Address) 2318 Lafayette Avenue

*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 St. Paul's Churchyard DATE OF BURIAL 12/15 1927

20. UNDERTAKER Wacker-Helders ADDRESS 2331 S. Bldg

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

