

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1367  
Do not use this space.

REC'D FEB 20 1939

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township New Primary Registration District No. 2002  
 (c) City Kansas City (d) Street No. St. Lukes Hosp Registered No. 380  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 570 Baby Rose Mary Koenig St. Lukes St. Mo  
2609 Surf Park (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan: 7. 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
0 0 22

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Kansas City (STATE OR COUNTRY) Missouri

FATHER 13. NAME R. M. Koenig

14. BIRTHPLACE (CITY OR TOWN) Missouri (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME Clara Y Hornor

16. BIRTHPLACE (CITY OR TOWN) Missouri (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) R. M. Koenig  
2609 Surf Park

18. BURIAL, CREMATION, OR REMOVAL PLACE Blount No 0 DATE 1-30-39

19. FUNERAL DIRECTOR (NAME) Thurman Mortuary (ADDRESS) Kansas City Mo

20. FILED Jan 29 1939 M. M. Browne Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 29 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1939, to Jan 29 1939. I last saw h. Jan 29 1939 alive on \_\_\_\_\_ m. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Spina Bifida in New Born.  
157 B.

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? clinical Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify Paul G. Gumpel M. D.  
 (Signed) Paul G. Gumpel  
 (Address) 315 Alameda Rd

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.

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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, above space should be left blank.**