

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38123
Registrar's No. 9362

30 DEC 17 1939 701
Registration District No. 1000

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County 1
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Mo. 12 Days
(Specify whether years, months or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")
(d) Street No. 1510 S. 10th St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME

Catherine Koenig 5

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 W

6. (b) Name of husband or wife William

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

7. Birth date of deceased March 5, 1897
(Month) (Day) (Year)

8. AGE: Years 42 Months 8 Days 16 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Charles Reisner

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

14. Maiden name Unknown
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature L Evelyn Walter

(b) Address 2836 S. Broadway

17. (a) Burial (b) Date thereof 11/22/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cem

18. (a) Signature of funeral director J. M. McFarlan

(b) Address 2301 Lafayette Ave

19. (a) Nov 29 1939 (b) J. T. Bredak
(Printed name of local registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 21, year 1939 hour 4:45 minute A. M.

21. I hereby certify that I attended the deceased from October 7, 1939 to November 21, 1939, that I last saw h. AL alive on November 21, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Cervix
Duration _____

Due to _____
Due to _____

Other conditions HO
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) _____
(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) Means of injury _____

23. Signature John F. Flynn (M. D. or other)
Address 1515 Lafayette, 11/21/39

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 L.R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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.