S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 10 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17856

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 494

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

1. PLACE OF DEATH:

(a) County Buchanan,

(b) City or town Saint Joseph, (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Methodist Hospital, (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days, (Specify whether

In this community 4 days, years, months or days)

520

3. (a) PRINT FULL NAME Marcine Katherine Koenig,

3. (b) If veteran, name war None,

3. (c) Social Security No. None,

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single,

6. (b) Name of husband or wife —

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

7. Birth date of deceased December 18, 1925, (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
14	4	14	hr. min.

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

10. Usual occupation Student,

11. Industry or business Public School,

FATHER
12. Name Frank Koenig,
13. Birthplace Rulo, (City, town, or county) Nebraska, (State or foreign country)

MOTHER
14. Maiden name Anna Fisher,
15. Birthplace Falls City, (City, town, or county) Nebraska, (State or foreign country)

16. (a) Informant Frank Koenig

(b) Address Rulo, Nebraska,

17. (a) Removal, (Burial, cremation, or removal) (b) Date thereof 5/2/40, (Month) (Day) (Year)

(c) Place: burial or cremation Falls City, Nebr.

18. (a) Signature of funeral director Peaton-Belsaw & Bowman Funeral

(b) Address 319 So. 10th. Str. Home

19. (a) May 3 1940 (Date received local registrar) (b) A J Nettlebush (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

0

(a) State Nebraska, (b) County Richardson,

(c) City or town Rulo, (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd. year 1940, hour 1:00 minute 15 a M.

21. I hereby certify that I attended the deceased from April 29, 1940, to May 2, 1940 that I last saw her alive on May 1, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Purpura Hemorrhagica (Thrombocytopenic Purpura)

Due to Idiopathic

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy no

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? ✓ (Specify type of place)

85

While at work? (e) Means of injury

23. Signature H. K. Wallace M.D. (M. D. or other) 1

Address 301 N. 8 St Joseph Mo Date signed May 2-40

(Licensed Embalmer's Statement on Reverse Side)

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 W M E Summerfield

Licensed Embalmer No. 3007

P. O. Address 319 So. St Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.