

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.

34073

Registrar's No.

8770

Registration District No.

791

Primary Registration District No.

1003

1. PLACE OF DEATH:

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

8. (a) PRINT FULL NAME Philip Koenig.

3. (b) If veteran,  
name war

3. (c) Social Security  
No. None

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Augusta Koenig,  
6. (c) Age of husband or wife if alive 64 years  
7. Birth date of deceased October 18th, 1867  
(Month) (Day) (Year)

8. AGE: Years 73 Months 0 Days 6 If less than one day  
hr. min.

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

10. Usual occupation Bottle Blower

11. Industry or business RETIRED

12. Name ? Koenig.

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

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

16. (a) Informant's own signature Augusta Koenig  
(b) Address 3415 Iowa Ave.

17. (a) Burial (b) Date thereof Oct. 28, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Eugenheim Bros.  
(b) Address 2627 Cherokee Street.

19. (a) OCT 24 1940 (b) J. J. Schaefer  
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County 24  
(c) City or town Saint Louis.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3415 Iowa Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 24th.  
year 1940. hour 6: minute 30 A. M.

21. I hereby certify that I attended the deceased from Sept. 1<sup>st</sup>, 1940, to October 24, 1940;  
that I last saw him alive on October 24, 1940;  
and that death occurred on the date and hour stated above.

Duration  
Immediate cause of death Carcinoma of Stomach. 1 mo  
Due to Carcinoma of Transverse Colon. 1 1/2 mo  
Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations Same as above. 110  
Of autopsy Same as above.  
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?

While at work? (Specify type of place) (e) Means of injury  
23. Signature Julius P. Rott (M. D. or other) M. D.  
Address 2603 Cherokee St. Date signed Oct. 24<sup>th</sup> 40

**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 E Morris

Licensed Embalmer No. 3360

P. O. Address 2623 Cherokee

**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.**