

S. No. 2
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State File No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 28 1943

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **8245**

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Enroute to City Hospital
(If not in hospital or institution, write street number or location) **3**

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **97**

(d) Street No. **816 Penrose**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ **0**

3. (a) PRINT FULL NAME **John Koenig**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

4. Sex **Male** **0**

5. Color or race **White** **0**

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 **about 1878**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

about 65 hr. _____ min.

9. Birthplace **Germany** **4**
(City, town, or county) (State or foreign country)

10. Usual occupation **Carpenter**

11. Industry or business _____

MOTHER FATHER { 12. Name **Unknown**

13. Birthplace **Germany** **4**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

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

16. (a) Informant **Mrs. Emma Trautwein**

(b) Address **816 Penrose**

17. (a) **Burial** (b) Date thereof **9-17-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Albert H. Hoppe Inc.**

(b) Address **4700 Washington Blvd**

19. (a) **SEP 16 1943** (b) _____
(Date received local health officer's certificate) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **15**
year **1943** hour **12:20** minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to **Coronary Occlusion**
Arteriosclerosis

Due to **94**

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

Major findings:
Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)

Means of injury _____

23. Signature **Alfred J. Perry** **2083**
(M. D. or other)

Address **Supply Company** Date signed **9/16/43**

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

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.....

J. Allen Davis Jr.

Licensed Embalmer No. *4053*

P. O. Address..... *City*

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, fact should be so stated above.