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

49438

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 3 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

32068

State File No.

Registration District No. 1003 Primary Registration District No. 1003 Registrar's No. 3213

1. PLACE OF DEATH:

(a) County

(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: St. Louis City Hospital
Max C. Starkloff Memorial
(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
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 2731 CHIPPEWA ST
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME CHARLES KOENIG

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex MO

5. Color or race W

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

6. (b) Name of husband or wife ELIZABETH

6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased ABOUT 80 YR 1865
(Month) (Day) (Year)

8. AGE: Years 80 Months — Days — If less than one day hr. min.

9. Birthplace ST. LOUIS (City, town, or county) MO (State or foreign country)

10. Usual occupation MOLDER RETIRED

11. Industry or business CARONDELET FOUNDRY

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

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

16. (a) Informant MRS OLGA KOENIG
(b) Address 6035 ARSENAL ST

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10 25 45 (Month) (Day) (Year)
(c) Place: burial or cremation ST. MATTHEWS

18. (a) Signature of funeral director K. RIEGSHAUSER
(b) Address 4228 SO KINGSHIGHWAY

19. (a) OCT 25 1945 (Date received local registrar) (b) J. F. Bledick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 22
year 1945 hour 8:15 minute P.M. M.

21. I hereby certify that I attended the deceased from October 19, 1945 to October 22, 1945;
that I last saw him alive on October 22, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Hepatitis - acute

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Same

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)

While at work? Means of injury

23. Signature K. R. Schlademan (M. D. or other)

Address 1515 Laf[illegible]tte Avenue Date signed 10/23/45

(Licensed Embalmer's Statement on Reverse Side)

K. R. Schlademan

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 Edwin D. Mc Dermo

Licensed Embalmer No. 3024

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, fact should be so stated above.