

FILED JAN 5 1946 STANDARD CERTIFICATE OF DEATH

State File No. 40792

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 433

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

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: So. East Mo. Hospital
(If not in hospital or institution, write street number or location)

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

In this community 4 hr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cape Girardeau

(c) City or town Cape Girardeau Mo
(If outside city or town limits, write "RURAL")

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

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

3. (a) PRINT FULL NAME Baby Koenig

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex M. race W

5. Color or race _____

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

(b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 21 45
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 7 hr. 1 min.

9. Birthplace Cape Girardeau Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Albert Koenig

13. Birthplace Berry Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Anna Hadler

15. Birthplace Berry Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Koenig

(b) Address Thompson Mo.

17. (a) Burial (b) Date thereof 12 22 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director W. J. Perry & Sons

(b) Address Perry Field Mo

19. (a) 12-29-1945 (b) C. C. Summers
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 21
year 45 hour 6 minute 02 P.M.

21. I hereby certify that I attended the deceased from Dec. 21
2:30 p.m. 1945 to 12/21/45 6:03 P.M. 1945
that I last saw him alive on Dec. 21 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Placenta Praevia Duration 2 7/8

Due to _____

Due to _____

Other conditions Club foot (mild)
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 160

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) _____ (Specify type of place)

While at work? _____ (Specify type of place)

(Specify type of place) _____ (Specify type of place)

23. Signature C. C. Summers (M. D. or other) _____
Address 12-29-1945 Date signed 12-29-1945

1500

RECEIVED

District Health Officer No. 4
District File Number 146-1524
Date Filed 1-7-46

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.

Not Embalmed.
Signed.....

Licensed Embalmer No.

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.