No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 14 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5657

1. PLACE OF DEATH:

(a) County .....

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

(c) Name of hospital or institution: 4269 Juniata St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (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. 4269 Juniata St.
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME ELIZABETH KOENIG

3. (b) If veteran, name war None

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

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Late Charles

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

7. Birth date of deceased Apr. (Month) 14 (Day) 1861 (Year)

8. AGE: Years 86 Months 1 Days 23 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housework

11. Industry or business .....

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 John Koenig
(b) Address 4269 Juniata St.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 6 10 47 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Chapel Of Mem.

18. (a) Signature of funeral director Kriegshauser Und.Co.
(b) Address 4228 So. Kingshighway Bl,

19. (a) JUN 9 1947 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7 year 1947 hour 5:50 minute P. M.

21. I hereby certify that I attended the deceased from Feb 5 1945, 19..., to June 7, 1947, that I last saw her alive on June 7, 1947, 19..., and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to .....

Due to .....

Other conditions R+ side paralysis
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....

Of autopsy .....

Duration

PHYSICIAN

Underline the cause of 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? — (e) Means of injury .....

23. Signature A. F. Plag (M. D. or other) M.D.

Address 3150 Morgan Ford Date signed 6/9/47

A.F Plag

Jefferson City Printing Co.

(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 Edwin D McDermott

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.