

## STANDARD CERTIFICATE OF DEATH

State File No. 25750

FILED SEP 15 1948

Registration District No. 68Primary Registration District No. 5268Registrar's No. 35

## 1. PLACE OF DEATH:

- (a) County Christian  
 (b) City or town Ozark Mo. Rural  
 (c) Name of hospital or institution: St. Lynn, Township 1  
 (If outside city or town limits, write "RURAL" and name of township)  
 (d) Length of stay: In hospital or institution 40 years  
 (Specify whether years, months or days)

In this community 40 years3. (a) PRINT FULL NAME Joe Koenig

3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Sarah Koenig 6. (c) Age of husband or wife if alive 79 years7. Birth date of deceased 10/7/1861  
(Month) (Day) (Year)8. AGE: Years 87 Months 3 Days 7 If less than one day hr. 11 min.9. Birthplace Austria  
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Don't know13. Birthplace Austria  
(City, town, or county) (State or foreign country)14. Maiden name Don't know15. Birthplace Don't know  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Sarah J. Koenig(b) Address Ozark Mo. Rural17. (a) Rural (b) Date thereof Aug 30 1948  
(Burial, cremation, or resowth) (Month) (Day) (Year)(c) Place: burial or cremation Ozark Post Office farm home Ozark Route18. (a) Signature of funeral director J. B. Chaffin(b) Address Ozark Mo19. (a) Aug 31 1948 (b) Louella Leonard  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County Christian  
 (c) City or town Ozark Mo. 17  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Rural  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17<sup>th</sup>  
year 1948 hour 9 minute 0 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 gun shot  
wounded self  
inflicted. Duration \_\_\_\_\_Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) suicide  
(b) Date of occurrence Aug 17-48(c) Where did injury occur? Christian Mo  
(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? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

23. Signature J. W. Maples (M. D. or other) CoronerAddress Clever Mo Date signed 8-19

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.

RECEIVED

Health Officer No. 67  
948-1044  
SEP 13 1948

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 T. B. Chaffin  
Licensed Embalmer No. 2192  
P. O. Address Ozark, Mo.

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.