

No. 300-10-47
5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 12 1948
Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34360
Registrar's No. 9390

Primary Registration District No. 1003

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

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: 2920 S Jefferson Av.
(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 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 2920 S Jefferson Av. 9
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME August E Koenig
(b) If veteran, name war no. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 29
year 1948 hour 2 minute 45 A.M.
21. I hereby certify that I attended the deceased from Oct 28, 1948, to Oct 29, 1948.
that I last saw him alive on Oct 28, 1948, and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Bertha Koenig 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Nov 10 1876
(Month) (Day) (Year)

Immediate cause of death Chronic myocarditis
Due to Cardiac decompensation
Due to arterio-sclerosis
bronchial asthma
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations 950
Of autopsy _____

8. AGE: Years 71 Months 11 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Tavern Owner

11. Industry or business _____

12. Name Bruno Koenig 4

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

14. Maiden name Beata Walters

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

16. (a) Informant Eus Koenig Jr

(b) Address 6450 Hoffman Av.

17. (a) Burial (b) Date thereof Nov. 1-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation S.S. Peter & Paul Cem.

18. (a) Signature of funeral director Wittbro. Leibe

(b) Address 2929 S. Jefferson Av.

19. (a) OCT 30 1948 J. B. Pasater
(Data received local registrar) (Registrar's signature)

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) (e) Means of injury _____
23. Signature [Signature] (M. D. or other) M.D.
Address 30145 Jefferson Date signed Oct 29 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 *H. M. Davis*

Licensed Embalmer No. *3741*

P. O. Address *2929 1/2 Jefferson av*

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.