

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

XC/2 385 592

Reg. No. 106 065

FILED DEC 2 1952

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2770

4008

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

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY ST. LOUIS COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY _____ | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFF. BRKS. MO. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2179 | |
| c. LENGTH OF STAY (In this place) 3 Days | | d. STREET ADDRESS (If rural, give location) 3855 SHAW | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION VET. ADM. HOSP. | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) JOHN | | b. (Middle) W. | |
| c. (Last) KOENIGSMARK | | 4. DATE OF DEATH (Month) (Day) (Year) 10/27/52 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED MARRIED | 8. DATE OF BIRTH 3/14/74 |
| 9. AGE (In years last birthday) 78 yrs. | | 10. MONTHS _____ | 11. DAYS _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Illinois Highway Commission | 11. BIRTHPLACE (City and State or Foreign Country) CARLINVILLE, ILL. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME ANTHONY KOENIGSMARK | |
| 13b. MOTHER'S MAIDEN NAME CLARA DUDA | | 14. NAME OF HUSBAND OR WIFE MARY KOENIGSMARK | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. SPAW | |
| 17. INFORMANT'S SIGNATURE OR NAME V. A. HOSPITAL RECORDS | | ADDRESS _____ | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION ARTERIOSCLEROTIC HEART DISEASE | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ | | INTERVAL BETWEEN ONSET AND DEATH _____ | |
| ANTECEDENT CAUSES _____ | | DUE TO (b) _____ | |
| Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. _____ | | DUE TO (c) _____ | |
| II. OTHER SIGNIFICANT CONDITIONS _____ | | - 4200 - | |
| Conditions contributing to the death but not related to the disease or condition causing death. _____ | | | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) NONE | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | |
| 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____ | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) V.A. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? _____ | | | |
| 22. I hereby certify that I attended the deceased from <u>10/24</u> 19 <u>52</u> , to <u>10/27</u> 19 <u>52</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE Robert A. Dwyer (Degree or title) M.D. | | 23b. ADDRESS V.A. HOSPITAL JEFF. BRKS. MO. | |
| 23c. DATE SIGNED 10/27/52 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE Oct. 30-1952 | |
| 24c. NAME OF CEMETERY OR CREMATORY National Cemetery | | 24d. LOCATION (City, town, or county) (State) Jefferson Barracks Mo. | |
| DATE REC'D BY LOCAL REG. 10-28-52 | | REGISTRAR'S SIGNATURE Herbert R. Dwyer M.D. | |
| 25. FUNERAL DIRECTOR'S SIGNATURE Wesley - Reddick | | ADDRESS 3604 Main St. St. Louis | |

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____

Student Embalmer

Signed

Robert Wheeler

Licensed Embalmer No. 2128

P. O. Address Louis 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, fact should be so stated above.