

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26588

State File No. ....

FILED JUL 31 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6125

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE<br><b>MISSOURI</b><br>b. COUNTY |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis, Mo.</b> |  | c. CITY OR TOWN <b>St. Louis</b>   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (In this place)<br><b>33 yrs</b>   |  | e. STREET ADDRESS (If rural, give location)<br><b>15 4301 Grace Ave</b>  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>   |  |  |   |

|  |            |                          |                            |  |
|--|------------|--------------------------|----------------------------|--|
| 3. NAME OF DECEASED<br>(Type or Print)<br><b>EMILY</b> | a. (First) | b. (Middle)<br><b>A.</b> | c. (Last)<br><b>KOENIG</b> | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>June 17, 1953</b> |
|--|------------|--------------------------|----------------------------|--|

|                         |                                  |   |  |  |                           |                         |                          |                         |
|-------------------------|----------------------------------|---|--|--|---------------------------|-------------------------|--------------------------|-------------------------|
| 5. SEX<br><b>female</b> | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>single</b> | 8. DATE OF BIRTH<br><b>March 7, 1897</b> | 9. AGE (In years last birthday)<br><b>56</b> | IF UNDER 1 YEAR<br>Months | IF UNDER 1 YEAR<br>Days | IF UNDER 1 YEAR<br>Hours | IF UNDER 1 YEAR<br>Min. |
|-------------------------|----------------------------------|---|--|--|---------------------------|-------------------------|--------------------------|-------------------------|

|  |  |  |  |
|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>school teacher</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Public schools</b> | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Addison, Ill.</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
|--|--|--|--|

|  |  |  |
|--|--|--|
| 13a. FATHER'S NAME<br><b>Rev. Frederick Koenig</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Clara Beyer Koenig</b> | 14. NAME OF HUSBAND OR WIFE<br><b>none</b> |
|--|--|--|

|   |                                      |  |         |
|---|--------------------------------------|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b> | 16. SOCIAL SECURITY NO.<br><b>no</b> | 17. INFORMANT'S SIGNATURE OR NAME<br><b>Miss Julia Koenig, 4301 Grace Avenue</b> | ADDRESS |
|---|--------------------------------------|--|---------|

|  |   |  |  |
|--|---|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b> |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>  | ANTecedent CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |  |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | II. OTHER SIGNIFICANT CONDITIONS<br>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?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|----------------------------------|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 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) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br><b>331x</b> |
|--|--|---|

22. I hereby certify that I attended the deceased from June, 1950, to June 17, 1953, that I last saw the deceased alive on June 17, 1953, and that death occurred at 8:55 Pm., from the causes and on the date stated above.

|   |                   |  |                                    |
|---|-------------------|--|------------------------------------|
| 23a. SIGNATURE<br><b>R. A. Neumann MD</b> | (Degree or title) | 23b. ADDRESS<br><b>3701 Grandel St</b> | 23c. DATE SIGNED<br><b>6-18-53</b> |
|---|-------------------|--|------------------------------------|

|  |                                   |   |  |
|--|-----------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b> | 24b. DATE<br><b>June 20, 1953</b> | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Concordia Cemetery</b> | 24d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b> |
|--|-----------------------------------|---|--|

|  |  |   |         |
|--|--|---|---------|
| DATE REC'D BY LOCAL REG.<br><b>JUN 19 1953</b> | REGISTRAR'S SIGNATURE<br><b>J. Carl Smith MD</b> | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Beiderwieden F. H. Inc., 1936 St. Louis Ave.</b> | ADDRESS |
|--|--|---|---------|

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

Dr. Robert A. Nussbaum  
3701 Grandel Sq.  
JE 4430 11:30 AM to 3:30 PM

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 None  
Signature of Student Embalmer

Signed Helix J. Trispin

Licensed Embalmer No. 349

P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.