

FILED DEC 27 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43352**  
Registrar's No. **11025**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Little Flower Nursing Home</b>			e. STREET ADDRESS (If rural, give location) <b>4257a Cleveland</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>MARY</b>		b. (Middle) <b>ELIZABETH</b>	c. (Last) <b>KOENIG</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>December 1, 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov. 2, 1868</b>	9. AGE (In years last birthday) <b>88</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>29</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Washington, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Henry Maune</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Louis Koenig</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Dr. George H. Koenig, Gulfport, Florida</b>		
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				INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Myocarditis</b>				<b>6 mo</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterio Sclerosis</b>				<b>10 yrs</b>
	DUE TO (c) <b>Paralysis left side</b>				<b>10 days</b>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Hangover 2 feet</b>				<b>5 days</b>
19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION <b>422.1</b>		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>none</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>none</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>none</b>			
22. I hereby certify that I attended the deceased from <b>Sept 15, 1956</b> to <b>Dec. 1, 1956</b> , that I last saw the deceased alive on <b>Dec. 1, 1956</b> , and that death occurred at <b>8:20A m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>Clayton Plump</b> M. D.		23b. ADDRESS <b>3933 So. Grand</b>		23c. DATE SIGNED <b>Dec. 3, 1956</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Dec. 3, 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Boles, Missouri</b>		
DATE REC'D BY LOCAL REG. <b>DEC 3 1956</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ambruster Mortuary, 6633 Clayton Rd.</b>		

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

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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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 4788

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.