

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003167

STATE FILE NUMBER

2 941

FILED FEB 10 1959

Registration District No.

Primary Registration District No.

Registrar No.

300
1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>ST. LOUIS</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>LITTLE FLOWER CONV HOME</i>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <i>4118 NEBRASKA</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>WILLIAM</i> Middle Last <i>KOENIG, SR.</i>			4. DATE OF DEATH Month <i>JAN</i> Day <i>26</i> Year <i>1959</i>				
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT 10, 1869</i>		9. AGE (In years last birthday) <i>89</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEPAINTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>	11. BIRTHPLACE (City and state or country) <i>ST. LOUIS, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13a. FATHER'S NAME <i>WILLIAM KOENIG</i>		13b. MOTHER'S MAIDEN NAME <i>NOT KNOWN</i>		14. NAME OF HUSBAND OR WIFE <i>MARGARET</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT Address <i>WM. KOENIG, JR. 594 RIDGE AVE.</i>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Coronary Vascular Renal Disease</i>	<i>5 yrs</i>	
	DUE TO (c) <i>Generalized atherosclerosis</i>	<i>15 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a))			19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>442x</i>	
20c. TIME OF INJURY Hour Month, Day, Year o.m. <i>None</i> p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <i>None</i>	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from <i>Aug 1 1957</i> to <i>Jan 26 1959</i> and last saw her/him alive on <i>Jan 20 1957</i> Death occurred at <i>9:55 P</i> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>Trupper Plump MD</i>	22b. ADDRESS <i>3133 S Grand</i>	22c. DATE SIGNED <i>Jan 27 1959</i>
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23a. BURIAL, CREMATION, REMOVAL <i>REMOVAL</i>	23b. DATE <i>1/28/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>NEW ST. MARCUS CEM</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Co., Mo.</i>
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24. FUNERAL DIRECTOR <i>J L ZIEGENHEIN & SONS 7027 GR</i>	ADDRESS <i>AVOIS</i>	25. DATE RECD. BY LOCAL REG. <i>JAN 27 '59</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Donald E. Ring*

Licensed Embalmer No. *4863*

P. O. Address *7027 Gravois*

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.