

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003872  
STATE FILE NUMBER

Feb 10 1959

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 351

300  
-57

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>ST LOUIS</b>	
b. CITY OR TOWN <b>DELLWOOD</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>DELLWOOD</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. MARY Hosp.</b> Length of stay in lb <b>3 days</b>		d. STREET ADDRESS (If outside, give location) <b>10311 NASHUA DR.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <b>THERESA G. KOENIG</b>			4. DATE OF DEATH Month Day Year <b>2-4-1959</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-1-1959</b>
9a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>NONE</b>	9b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9c. AGE (In years last birthday) <b>3</b>	9d. IF UNDER 1 YEAR Months <b>3</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>
10a. FATHER'S NAME <b>PAUL J. KOENIG</b>		10b. MOTHER'S MAIDEN NAME <b>ANNA IANNICOLA</b>	10c. NAME OF HUSBAND OR WIFE <b>NONE</b>
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		11. SOCIAL SECURITY NO.	11. INFORMANT Address <b>Paul J. Koenig 10311 Nashua</b>
12. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arctic Brain Damage</b>			12. INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			13. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		14. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
15. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
16. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		16. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	16. CITY, TOWN, OR LOCATION COUNTY STATE
17. I attended the deceased from <b>Feb 2/59</b> to <b>Feb 4/59</b> and last saw her alive on <b>Feb 4/59</b> Death occurred at <b>4:40 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
18. SIGNATURE (Degree or title) <b>Hugh M. Mestas M.D.</b>		18. ADDRESS <b>3438 82 Grand</b>	
19. DATE SIGNED <b>2/4/59</b>			
19a. BURIAL, CREMATION, OR OTHER DISPOSITION <b>REMOVAL</b>	19b. DATE <b>2-5-1959</b>	19c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cem.</b>	19d. LOCATION (City, town or county) (State) <b>St. Louis MO.</b>
20. FUNERAL DIRECTOR ADDRESS <b>Ambermell 3819 So Grand St</b>		20. DATE RECD. BY LOCAL REG. <b>2-4-59</b>	20. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>

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 *[Handwritten Signature]* .....

Licensed Embalmer No. *4611* .....

P. O. Address *[Handwritten Address]* .....

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.