

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019345
STATE FILE NUMBER

FILED JUN 15 1959

Registration District No. _____ Primary Registration District No. _____ Registered No. **5291**

300
-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		Length of stay in lb D.O.A.	d. STREET ADDRESS (If outside, give location) 2708 So. 13th St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CLARA Middle P. Last KOENIG			4. DATE OF DEATH Month May Day 31 Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1887
9. AGE (In years last birthday) 71		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) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alfred W. Koenig	
13b. MOTHER'S MAIDEN NAME Emily P. Thelle		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wichita Falls, Texas.		17. ADDRESS Col. Ira R. Koenig 2529 Fain Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart Disease DUE TO (b) Generalized Arterio sclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420-0			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Patrick Taylor Corauer (Degree or title) _____		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 6.2.59.		22d. _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 4, 1959	
23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		23d. LOCATION (City, town, or country) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. JUN 2 '59	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D. <i>m&B.</i>			

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 *William S White*

Licensed Embalmer No. *4281*

P. O. Address *Madison, Wis*

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.