# DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

**59–039240**
STATE FILE NUMBER

FILED VS DEC 15 1959

Registration District No. 53 Primary Registration District No. 0000 Registrar's No. 461

AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY: Cape Girardeau
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Gordonville Mo.
Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION:
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: ~~Perry~~ CAPE GIRARDEAU
c. CITY OR TOWN: Near NewWells
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location):
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Benjamin Middle: Last: Koenig
4. DATE OF DEATH: Month: Dec. Day: 7 Year: 1959
5. SEX: M.
6. COLOR OR RACE: W.
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 11-28-1864
9. AGE (last birthday): 95
IF UNDER 1 YEAR: Months: 0 Days: 9
IF UNDER 24 HR: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Andrew Koenig
13b. MOTHER'S MAIDEN NAME: Christena Hoertling
14. NAME OF HUSBAND OR WIFE: Margrete Koenig
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Otto Koenig Address: Gordonville Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of urinary bladder — INTERVAL BETWEEN ONSET AND DEATH: 2½ yrs.
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): Generalized arteriosclerosis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Feb. 11, 1958 to Dec 7, 1959 and last saw ~~him~~ alive on Dec 6, 1959
Death occurred at 10:30 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J. N. Jaeger (Degree or title) M.D.
22b. ADDRESS: Jackson, Mo.
22c. DATE SIGNED: Dec 8, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12-9-59
23c. NAME OF CEMETERY OR CREMATORY: NewWells
23d. LOCATION (City, town, or county) (State): Near NewWells Mo.

24. FUNERAL DIRECTOR: Deneke-Laird ADDRESS: Jackson Mo.
25. DATE RECD. BY LOCAL REG.: 12-11-1959
26. REGISTRAR'S SIGNATURE: Irma Karsten

(Licensed Embalmer's Statement on Reverse Side)

JAN 7 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed R. O. Laird

Signature of Student Embalmer

Licensed Embalmer No. 4538

P. O. Address Jackson, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.