

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000525

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Registration District No. _____ Primary Registration District No. 3008 Registrar's No. 16 STATE FILE NUMBER _____

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>1 Hr. 30. M.</u>	c. CITY OR TOWN <u>Mokane</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Callaway Mem. Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>None</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle _____ Last <u>Koenig</u>			4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1885</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Americus, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William Koenig</u>		13b. MOTHER'S MAIDEN NAME <u>Alida Stockhorst</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Elizabeth Koenig</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Mrs. Kennon Whyte, Mokane, Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Head injuries, probably skull fracture</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Internal injuries, broken right arm and</u>		
DUE TO (c) <u>broken pelvic.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Head on collision, His own truck and</u>	
20c. TIME OF INJURY Hour <u>3:30</u> a.m. _____ p.m. _____	Month, Day, Year <u>Jan, 22, 60</u>	School Bus	
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, farm, factory, street, office bldg., etc.) <u>Hiway 94 3 Mi East of Mokane</u>	20f. CITY, TOWN, OR LOCATION <u>Mokane</u>	COUNTY <u>Callaway</u> STATE <u>Mo</u>

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at 5:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Denzil G. Browning coroner Fulton, Missouri</u>		22b. ADDRESS <u>Fulton, Missouri</u>	22c. DATE SIGNED <u>1-23-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 25, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mokane Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mokane, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Mansin Funeral Home, Fulton, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan. 23- 1960</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Marshall C. Black

Licensed Embalmer No. 4710

P. O. Address Fulton

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