

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-009891**

**FILED VS MAR 21 1960 38**

Registration District No. \_\_\_\_\_ Primary Registration District No. 3006 Registrar's No. 157

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolf</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>19 days</u>	c. CITY OR TOWN <u>Higbee</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Missouri Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Box 352</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>Koenig</u>			4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-96</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(retired)</u>		11. BIRTHPLACE (City and state or country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>Fritz Koenig</u>		13b. MOTHER'S MAIDEN NAME <u>Marie Myers</u>		14. NAME OF HUSBAND OR WIFE <u>Mollie 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>490-09-6300</u>		17. INFORMANT <u>Hospital Chart - University Hospital - Columbia, Mo</u> Address _____		

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>CEREBRAL THROMBOSIS</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u>	
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE; OBSTRUCTIVE PNEUMONIA</u>		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	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>2/23/60</u> to <u>3/13/60</u> and last saw him <u>3/13/60</u> Death occurred at <u>4:17 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>Jack Sander MD</u>		22b. ADDRESS <u>Univ. of Mo. Med Center</u>		22c. DATE SIGNED <u>3/13/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>3/14/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HIGBEE, MISSOURI</u>		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <u>PARKERS FUNERAL SERVICE</u>		ADDRESS <u>COLUMBIA MISSOURI</u>	25. DATE RECD. BY LOCAL REG. <u>Mar 14 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

APR 15 1960

MAR 22 1960

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

*JW Phillips*

Licensed Embalmer No. 4897

P. O. Address Columbia, MS

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.