

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-037094  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2786

FILED OCT 17 1962

VS 300  
Rev. 4/59

4005

24013

3

4 1

5 1

6

7 0

8 0

9332X

10

11

1246-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)   |   |
| a. COUNTY <b>St. Louis</b>   |   | a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Richmond Hts.,</b>   |   | c. CITY OR TOWN <b>Florissant</b>   |   |
| Length of stay in 1b<br><b>12 Days</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>  |   | d. STREET ADDRESS (If outside, give location)<br><b>115 Aubuchon St.,</b>   |   |
| Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)  |   |   | 4. DATE OF DEATH  |
| First <b>EDNA</b> Middle <b>MARGARET</b> Last <b>KOENIG</b>  |   |   | Month <b>Sept.</b> Day <b>25</b> Year <b>1962</b>   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/8/04</b>   |
| 9. AGE (last birthday)<br><b>58</b>  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HR<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House-wife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Bland Missouri</b>   |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |   | 13a. FATHER'S NAME<br><b>Fred Bock</b>  |   |
| 13b. MOTHER'S MAIDEN NAME<br><b>Amelia Beihle</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Clarence A. Koenig</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO. _____   |   |
| 17. INFORMANT<br><b>Clarence A. Koenig-115 Aubuchon St.,</b>   |   | Address <b>Florissant, Mo.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident - Thrombosis</b>   |   |   |   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |   |   |   |
| DUE TO (b) <b>Atherosclerosis</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)  |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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 checked="" 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>8/2/62</u> to <u>9/25/62</u> and last saw her alive on <u>9/24/62</u><br>Death occurred at <u>12:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>Robert H. Ramsey, M.D.</b>  |   | 22b. ADDRESS<br><b>25 S. Florissant Ferguson 35/40</b>  | 22c. DATE SIGNED<br><b>9/26/62</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>9/28/62</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Hill Cemetery</b>   | 23d. LOCATION (City, town, or county)<br><b>St. Louis County, Mo.</b>   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>WHITE-MULLEN MORTUARY INC., FERGUSON, MO</b>  |   | 25. DATE RECD. BY LOCAL REG.<br><b>9-26-62</b>  | 26. REGISTRAR'S SIGNATURE<br><b>John C. Murphy M.D.</b>   |

USE BLACK INK OR TYPEWRITER RIBBON

Dr Ramsey  
for 4-05-60 - 3:00 - 6:00 - Wed.

**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 Reinhold K. Lehmann

Licensed Embalmer No. 3395

P. O. Address St. Louis 35 MO

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.