MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

6436

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 1644

Township ..... Primary Registration District No. 1003 Registered No. .....

City St Louis (No. City Hospital St. ..... Ward)

2. FULL NAME John McCune

(a) Residence. No. 5806 Lillian St. 7 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June Unknown

7. AGE: abt. 86 YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Nihil
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: John McCune Sr
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Nor
12. MAIDEN NAME OF MOTHER: Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Hospital Information

14. INFORMANT: E Roman
(Address) City Hospital

15. FILED FEB 17 1927 19..... Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 16 1927

17. I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to Feb 16, 1927 that I last saw him alive on Feb 16, 1927, and that death occurred, on the date stated above, at 9.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy - Cerebral Hemorrhage

82H (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 74 A 1 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature], M.D.

7/16, 1927 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Dompham Mo. DATE OF BURIAL: Feb. 18 1927

20. UNDERTAKER: Hy Leidner Und Co. ADDRESS 1417 N Market St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

M Caine