DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

NOV 13 1939

NOV 11 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34162

87009000

Registration District No. 791 1003

Primary Registration District No.

Registrar's No.

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.

1. PLACE OF DEATH:

(a) County: 2

(b) City or town: St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3859a Cottage Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DEACESED:

(a) State (b) County: 1

(c) City or town: St. Louis 11
(If outside city or town limits, write "RURAL")

(d) Street No.: 3859a Cottage Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Catherine M. Kunz. 520

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife: Henry Kunz

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: May (Month) 31 (Day) 1862 (Year)

8. AGE: Years 77 Months 4 Days 8 If less than one day hr. min.

9. Birthplace: St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: At Home

11. Industry or business:

FATHER
12. Name: Casper Dickbrader
13. Birthplace: Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Mary Fitzsimmons
15. Birthplace: Ireland (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Walter Mathews
(b) Address: 3859a Cottage Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 12, 39 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cemetery

18. (a) Signature of funeral director: Cullinane Bros.
(b) Address: 1710 N. Grand Blvd.

19. (a) OCT 11 1939 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 9 year 1939 hour 11 am minute M.

21. I hereby certify that I attended the deceased from Oct. 4 1939 to Oct. 9 1939 that I last saw her alive on Oct. 9 1939 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Arterio sclerosis

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations:

Of autopsy: No autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Cordelia Puckett (M. D. or other)

Address: 3867 Cottage Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 ....., Registered Apprentice No. ..... working under my personal supervision.

Signed Fred Frick

Licensed Embalmer No. 3186

P. O. Address St. Louis, 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 this body is not embalmed, above space should be left blank.