S. No. 2
—9-4-41
5-17-39
I X29484

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 17 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26190

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 161T

1. PLACE OF DEATH:
(a) County St. Louis County
(b) City or town Jefferson Barracks, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Hospital (Specify whether years, months or days)
In this community 120 days.

2. USUAL RESIDENCE OF DECEASED: 999
(a) State Illinois (b) County Sangamon 11
(c) City or town Springfield 0
(If outside city or town limits, write "RURAL")
(d) Street No. 1227 South 12th Str.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Albert A Kunznick
3. (b) If veteran, name war World War.
3. (c) Social Security No. SS 348-09-4726
4. Sex Male.
5. Color or race White. 0
6. (a) Single, widowed, married, divorced Married. 1
6. (b) Name of husband or wife Jessie May Kunznick.
(c) Age of husband or wife if alive 43 years
7. Birth date of deceased April (Month) 1 (Day) 1897. (Year)

8. AGE: Years	Months	Days	If less than one day
46	3	12	hr. min.

9. Birthplace Brockton (City, town, or county) Alabama. 1 (State or foreign country)
10. Usual occupation Tool grinder.
11. Industry or business Montgomery Ward and Co.
FATHER
12. Name Jacob Kunznick
13. Birthplace Germany (City, town, or county) 4 (State or foreign country)
MOTHER
14. Maiden name Mary Kron
15. Birthplace Austria (City, town, or county) 4 (State or foreign country)
16. (a) Informant Government Records
(b) Address Vet. Adm. Fac., Jeff.Bks., Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/14/43 (Month) (Day) (Year)
(c) Place: burial or cremation Springfield, Ill
18. (a) Signature of funeral director Albert H. Hoppe, Inc
(b) Address 4700 Washington Blvd.
19. (a) JUL 15 1943 (Date received local registrar) (b) C. L. McLaurin M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13 year 1943 hour 6 minute 15 P. M.
21. I hereby certify that I attended the deceased from March 16, 1943, to July 13, 1943. that I last saw him alive on July 13, 1943. and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Poliosencephalitis	6 mo.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations None.	
Of autopsy None.	

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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) Nature of injury
23. Signature L. M. COCHRAN, M.D., C (M. D. or other)
Address Chief Medical Officer Date signed 7-14-43
Vet. Adm. Fac., Jeff.Bks., Mo.

(Licensed Embalmer's Statement on Reverse Side)

JUL 23 1943

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. G. W. Wilkinson

Licensed Embalmer No. 3 5 7 5

P. O. Address.....

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, fact should be so stated above.