

FILED APR 24 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13196

State File No.

No. 300

10. 48

580

BIRTH NO. _____ REG. DIST. NO. 182 PRIMARY REG. DIST. NO. 5686 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY <u>Leinn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Leinn</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Jefferson Creek</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4 miles N. Leaside</u>		d. STREET ADDRESS (If rural, give location) <u>4 miles N. Leaside, 0580</u>	
3. NAME OF DECEASED a. (First) <u>CLAUDE</u> b. (Middle) <u>SAMUEL</u> c. (Last) <u>KUHN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 11, 1951</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr 15, 1879</u>
9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>26</u>	IF UNDER 18 HRS. Hours <u>1</u> Min. <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (State or foreign country) <u>Ohio</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Jasper Kuhn</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Louise</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; no or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Louise Kuhn Jones, Mo.</u> ADDRESS _____
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Herpes zoster</u> <u>4201C</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>49</u> , to <u>April 11</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>51</u> , and that death occurred at <u>2:10 p. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>J.P. Martin</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>Browning, Mo</u>	23c. DATE SIGNED <u>April 16, 51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4-14-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Leaside Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Leaside, Missouri</u>
DATE REC'D BY LOCAL REG. <u>April 19-1951</u>	REGISTRAR'S SIGNATURE <u>Mrs Budie Kelley</u>	165	25. FUNERAL DIRECTOR'S SIGNATURE <u>Brothers Funeral Home, Leaside, Mo</u> ADDRESS _____

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

Date Received: APR 20 1951
DISTRICT HEALTH OFFICE #2
District File Number 4-57-765
Date Filed: APR 20 1951

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.

Signed W. R. Wright

Signed _____
Student Embalmer

Licensed Embalmer No. 4655

P. O. Address Acade 140

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.