

FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29041

State File No. 7511

318

1003

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Mo.)		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, 2139			
d. FULL NAME OF HOSPITAL OR INSTITUTION Route City Hospital				d. STREET ADDRESS (If rural, give location) 13 5341 Magnolia Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Charles		b. (Middle)		c. (Last) Kutz		4. DATE OF DEATH (Month) (Day) (Year) Aug. 11, 1954	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Dec. 13, 1902	
9. AGE (In years last birthday) 51		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filling Station		11. BIRTHPLACE (City and State or Foreign Country) Caskaska, Illinois,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME George Kutz		13b. MOTHER'S MAIDEN NAME Dora Gillenberg		14. NAME OF HUSBAND OR WIFE Josephine Kutz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Nil. 489-10-5799		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Josephine Kutz, 5341 Magnolia Ave.			
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) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular disease DUE TO (c) Obesity II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Obesity				INTERVAL BETWEEN ONSET AND DEATH 8 yrs 12 yrs years	
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) 443 X			
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 4-1, 1954 to 8-11, 1954, that I last saw the deceased alive on 8-9, 1954, and that death occurred at 11:45 a.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Charles Montanari M.D.				23b. ADDRESS 5147 Daggett Ave		23c. DATE SIGNED 8-12-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-14-54		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.	
DATE REC'D BY LOCAL REG. AUG 13 1954		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Paul C. Calcaterra, 5140 Daggett Ave			

(Licensed Embalmer's Statement on Reverse Side)

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

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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
Student Embalmer

Signed J. Wm. Dunkley
Licensed Embalmer No. 3153
P. O. Address St. Louis 8 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, fact should be so stated above.