

FILED MAR 31 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003 State File No. 9848
Registrar's No. 2494

318

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Macon	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. LENGTH OF STAY (in this place) Oakley	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis, City Hospital		e. STREET ADDRESS (If rural, give location) ---	
3. NAME OF DECEASED a. (First) Billy (Type or Print)		b. (Middle) Lee	
c. (Last) Kuns		4. DATE OF DEATH (Month) (Day) (Year) Mar. 17, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH June 5, 1924
9. AGE (In years last birthday) 30		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber	11. BIRTHPLACE (City and State or Foreign Country) / Illinois,
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lee R. Kuns	
14. MOTHER'S MAIDEN NAME Elenor Gillispe		15. NAME OF HUSBAND/OR WIFE Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO. Unknown	
18. INFORMANT'S SIGNATURE OR NAME Elmer Kuns, Oakley, Ill.		19. 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) Fracture of Skull; Brain Injury; suffered when deceased fell backwards striking head on sidewalk at 1312 Mississippi Ave., March 16th 1955 about 3:35 pm.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Accident	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis MO MO	
21d. TIME OF INJURY Mar 16 55/25	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? E9035	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:00 A.M. , from the causes and on the date stated above. 44			
23a. SIGNATURE Patrick P. Taylor Carver		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 3.18.55		23d. DEGREE OR TITLE	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-18-55	24c. NAME OF CEMETERY OR CREMATORY North Fork Cem.	24d. LOCATION (City, town, or county) (State) Decatur, Ill.
DATE REC'D BY LOCAL REG. MAR 18 1955	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Adbert H. Hoppe 4700 Washington.	

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

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.....
Signature of Student Embalmer

Signed.....
John S. Penne

Licensed Embalmer No. *419*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.