

FILED APR 28 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13528**
3552

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3552	
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 town or city) ST. LOUIS		c. LENGTH OF STAY (in this place) 10 YRS		c. CITY OR TOWN ST. LOUIS		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2654 CHOUTEAU				22. STREET ADDRESS (If rural, give location) 2654 CHOUTEAU 2229			
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM		b. (Middle) A.		c. (Last) KARNES		4. DATE OF DEATH (Month) (Day) (Year) APR-20-1955	
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH AUG-5-1889	
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) ANUTT - MO	
12. CITIZEN OF WHAT COUNTRY U.S.		13a. FATHER'S NAME PHILLIP KARNES		13b. MOTHER'S MAIDEN NAME MARY BAKER		14. NAME OF HUSBAND OR WIFE MARY KARNES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 498-18-5241		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Mrs. Mary Karnes Chouteau			
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis ANTECEDENT CAUSES DUE TO (b) arterio-sclerotic heart disease DUE TO (c) General arterio-sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Paralytic left arm				INTERVAL BETWEEN ONSET AND DEATH 7 days	
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200			
22. I hereby certify that I attended the deceased from Apr. 1 , 19 54 , to Apr. 20 , 19 55 , that I last saw the deceased alive on April 19 , 19 55 , and that death occurred at 9:10 a. m., from the causes and on the date stated above.							
23a. SIGNATURE Dr. Leo J. Young, M.D.				23b. ADDRESS 2021 S. Jefferson, F.C.L. No		23c. DATE SIGNED 4/20/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 4-23-55		24c. NAME OF CEMETERY OR CREMATORY ANUTT CEM.		24d. LOCATION (City, town, or county) (State) ANUTT - MO	
DATE REC'D BY LOCAL REG. APR 21 1955		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE L. B. Tamara		ADDRESS 6107 Natural Bridge	

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 *Elmo K. Padwell*

Licensed Embalmer No. *407*

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.