

FILED AUG 2- 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24001**

318

PRIMARY REG. DIST. NO. **1003** Registrar's No. **6137**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>6137</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____					
b. CITY OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>1203 Hamilton Avenue.</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b> b. (Middle) _____ c. (Last) <b>Kuntz.</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>July 13, 1955.</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>August 25, 1896.</b>			
9. AGE (In years last birthday) <b>58</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>18</b>		IF UNDER 4 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Mortuary</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>Cincinnati, Ohio.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			13a. FATHER'S NAME <b>Michael Kuntz.</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Gross.</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Beatrice Kuntz.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>489-03-6074</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Beatrice Kuntz.</b> ADDRESS <b>1203 Hamilton Ave.</b>					
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, asthenia, etc. It means the disease, injury, or complication which caused death.				<p align="center"><b>MEDICAL CERTIFICATION</b></p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Generalized Carcinomatosis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Carcinoma Cecum</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>  <b>10 mos.</b>	
19a. DATE OF OPERATION <b>9-6-54</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Cecum</b>				20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO			
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? <b>153x</b>					
22. I hereby certify that I attended the deceased from <b>9-1</b> , 19 <b>54</b> , to <b>7-13</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>7-12</b> , 19 <b>55</b> , and that death occurred at <b>9:00 P.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>John F. Shaner MD</b>			23b. ADDRESS <b>3720 Washington</b>			23c. DATE SIGNED <b>7-14-55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>July 16, 1955.</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri.</b>			
DATE REC'D BY LOCAL REG. <b>JUL 16 1955</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith - MD</b> <i>acm</i>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Beiderwieden Funeral Home Inc.</b> ADDRESS _____					

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. 34

working under my personal supervision.

Student Morse  
Signature of Student Embalmer

Signed Delis J. Krupin

Licensed Embalmer No. 34

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.