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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18172

FILED MAY 25 1956

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4780

1. PLACE OF DEATH  
a. COUNTY Missouri

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 township) OR TOWN St. Louis

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

d. FULL NAME OF HOSPITAL OR INSTITUTION Masonic Hospital

d. STREET ADDRESS (If rural, give location) 5351 Delmar

3. NAME OF DECEASED (Type or Print)  
a. (First) Annie  
b. (Middle) Laura  
c. (Last) Kunkle

4. DATE OF DEATH (Month) (Day) (Year)  
5-16-1956

5. SEX F

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W

8. DATE OF BIRTH 9-10-1867

9. AGE (In years last birthday) 88  
if UNDER 1 YEAR Months 7 Days 13  
if UNDER 1 HR. Hours    Min.   

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_

11. BIRTHPLACE (City and State or Foreign Country) Foster, Kentucky

12. CITIZEN OF WHAT COUNTRY? \_\_\_\_\_

13a. FATHER'S NAME Austin Leming

13b. MOTHER'S MAIDEN NAME Mary Maxfield

14. NAME OF HUSBAND OR WIFE Jacob Kunkle, deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Leona C. Robertson, 5351 Delmar Blvd., Masonic Home of Mo.

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)  
MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Intestinal Obstruction  
INTERVAL BETWEEN ONSET AND DEATH 4 Dys.  
\*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  
ANTECEDENT CAUSES  
DUE TO (b) Carcinoma of Colon with Perforation 4d  
DUE TO (c) Generalized Arteriosclerosis 20 Yrs  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION \_\_\_\_\_

19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

20. AUTOPSY? YES  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)  
153x

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) \_\_\_\_\_

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from 10-55, to 5-15-, 1956, that I last saw the deceased alive on 5-15-, 1956, and that death occurred at 12:30A., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Harold C. Walter, M.D.

23b. ADDRESS 3720 Washington Ave.,

23c. DATE SIGNED MAY 16 1956

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 5-18-56

24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery

24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.

DATE REC'D BY LOCAL REG. MAY 16 1956

REGISTRAR'S SIGNATURE [Signature]

25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Alexander & Sons 6175 Delmar

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Student Embalmer

Signed

*Jos. E. McCulloch*

Licensed Embalmer No.

2460

P. O. Address

6176 Delmar

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.