

FILED JUN 29 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22422

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1389

1. PLACE OF DEATH
a. COUNTY St. Louis

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 Koch, Mo

c. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital

e. STREET ADDRESS (If rural, give location) 19 4245 West Pine Blvd 2199

3. NAME OF DECEASED (Type or Print)
a. (First) Max Amaza b. (Middle) Mc c. (Last) Cune

4. DATE OF DEATH (Month) (Day) (Year) 6-4-56

5. SEX Male

6. COLOR OR RACE White

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

8. DATE OF BIRTH 12-4-12

9. AGE (In years last birthday) 43 IF UNDER 1 YEAR Months 5 Days _____ IF UNDER 2 HRS. Hours _____ Min. _____

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

10b. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE - (City and State or Foreign Country) Colorada

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Amaza Mc Cune

13b. MOTHER'S MAIDEN NAME Emma Black

14. NAME OF HUSBAND OR WIFE Pearl Mc Cune

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) W.W. 2

16. SOCIAL SECURITY NO. 490-12-6765

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Medical Records at Koch Hosp

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, asphyxia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tb
ANTECEDENT CAUSES DUE TO (b) _____
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic Alcoholism

INTERVAL BETWEEN ONSET AND DEATH 4 yrs?

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)

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 1-4-55, 1955, to 6-6-56, 1956, that I last saw the deceased alive on 6-4-56, 1956, and that death occurred at 11.10PM from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Harold J. Russell

23b. ADDRESS Koch Hospital

23c. DATE SIGNED 6-5-56

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

24b. DATE 6-7-56

24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery

24d. LOCATION (City, town, or county) (State) Impo, Mo.

DATE REC'D BY LOCAL REG. 6-6-56

REGISTRAR'S SIGNATURE Herbert R. Donke MD

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.

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 *Edmond R. Remelius*

Licensed Embalmer No. *428*

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.