

FILED OCT 18 1956

STANDARD CERTIFICATE OF DEATH

35762

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar No. **8886**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN MAPLEWOOD 4544	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PARK LANE HOSP.		d. STREET ADDRESS 3517 CAMBRIDGE AVE.	
Length of stay in 1b 8 DAYS		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUIS Middle E. Last KOONTZ			4. DATE OF DEATH Month SEPT. Day 25 Year 1956
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-13-1887
9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months 11 Days 12	IF UNDER 24 HRS. Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ARCHITECT		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	11. BIRTHPLACE (City and state or country) BUNCETON, MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH KOONTZ	
14. MOTHER'S MAIDEN NAME LYDA FUNKHOUSER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I	
16. SOCIAL SECURITY NO. 487-20-6632		17. INFORMANT BETTY SHEPHARD, Address ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus DUE TO (b) Arterio-Sclerosis Gen DUE TO (c) 260X PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour 9:30 Month Aug Day 1 Year 1956	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		20g. COUNTY	
20h. STATE		21. I attended the deceased from Jan 1 1950 to Sept 25 1956 and last saw him alive on Sept 26 56 Death occurred at 9:30 Pm on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Doctor or title) Carl E. Smith M.D.		22b. ADDRESS 227 E. Ludlow	
22c. DATE SIGNED 9-26-56		23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	
23b. DATE 9-28-1956		23c. NAME OF CEMETERY OR CREMATORY Missouri Crematory	
23d. LOCATION (City, town, or county) St. Louis, Mo.		23e. STATE	
24. FUNERAL DIRECTOR JAY B. SMITH ADDRESS Maplewood 17, Mo.		25. DATE RECD. BY LOCAL REG. SEP 27 1956	
26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.			

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.....

Licensed Embalmer No. 40

P. O. Address Maple

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.