

FILED JAN 28 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2453**

BIRTH NO. _____ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058** Registrar's No. **50**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Saint Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Charles	
b. CITY OR TOWN Saint Charles	c. LENGTH OF STAY (in this place) 70 years	c. CITY OR TOWN Saint Charles	d. In 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 118 Boonslick		e. STREET ADDRESS (If rural, give location) 118 Boonslick	
3. NAME OF DECEASED a. (First) Arthur b. (Middle) _____ c. (Last) Kunz		4. DATE OF DEATH (Month) (Day) (Year) Jan. 18, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 1, 1886
9. AGE (in years last birthday) 70	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist	11. BIRTHPLACE (City and State or Foreign Country) Saint Charles, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John Kunz	13b. MOTHER'S MAIDEN NAME Susan Maxwell	14. NAME OF HUSBAND OR WIFE Ruth Moore	
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. unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs. Ruth Kunz, St. Charles, Mo. ADDRESS _____	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia ANTECEDENT CAUSES DUE TO (b) Passive Congestion of Lungs DUE TO (c) Atherosclerotic Heart Disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Uremic	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? 2 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) 4200	
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? _____	
22. I hereby certify that I attended the deceased from Dec 1956 , to Jan 18, 1957 , that I last saw the deceased alive on Jan 17, 1957 , and that death occurred at 7:55 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE W. H. Poggendorf (Degree or title) MD	23b. ADDRESS St. Charles, Mo.	23c. DATE SIGNED Jan 21, 1957	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Jan 22, 1957	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	24d. LOCATION (City, town, or county) (State) Saint Louis Co., Mo.
DATE RECEIVED BY LOCAL REG. Jan 21 1957	REGISTRAR'S SIGNATURE Fannie Hamilton	25. FUNERAL DIRECTOR'S SIGNATURE R.C. Dally ADDRESS St. Charles, Mo.	

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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.....
[Handwritten Signature]

Licensed Embalmer No.....
[Handwritten Number]

P. O. Address.....
[Handwritten Address]

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.