

No. 900
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6802

FILED FEB 18 1957

State File No.

BIRTH NO. _____ REG. DIST. NO. 312 PRIMARY REG. DIST. NO. 531 Registrar's No. 153

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>University City</u>		c. CITY OR TOWN <u>University City</u>	d. Is residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>43 yrs</u>		e. STREET ADDRESS (If rural, give location) <u>7355 Pershing Avenue</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>7355 Pershing Ave.</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ALBERT</u>	b. (Middle) <u>=</u>	c. (Last) <u>KUNTZ</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 19 1957</u>
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>	8. DATE OF BIRTH <u>MARCH 19-1879</u>	9. AGE (In years last birthday) <u>77</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 24 HRS Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROFESSOR</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>ANATOMY</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Batesville, Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Andrew Kuntz</u>	13b. MOTHER'S MAIDEN NAME <u>BARBARA Butz</u>	14. NAME OF HUSBAND OR WIFE <u>EMMA MAGSICK</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>487-36-6957</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS EMMA KUNTZ 7355 Pershing Av</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>gall stone</u> DUE TO (c) <u>Age.</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>no operation</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from Aug 15, 1955, to 5:49 a.m., that I last saw the deceased alive on Jan 15, 1957, and that death occurred at 12:05 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Chas Hugh Heelover M.D.</u>	23b. ADDRESS <u>Humboldt - Rly</u>	23c. DATE SIGNED <u>1/19/57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>1-19-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	24d. LOCATION (City, town, or county) (State) <u>CHARLES CITY, IOWA</u>
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DATE REC'D BY LOCAL REG. <u>1-19-57</u>	REGISTRAR'S SIGNATURE <u>Hubert A. Domke MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BEIDERWIEDEN F.H. 1936 St Louis</u>
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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  _____

Licensed Embalmer No. 445

P. O. 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.