Health, Welfare Public Service

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SL # 139

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 33760 8133

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS. ADM. HOSP. — Length of stay in Ib 82 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE ILLINOIS b. COUNTY SAINT CLAIR
c. CITY OR TOWN BELLEVILLE 8120 — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 123 MASCOUTAH — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First WILLIAM Middle L. Last KUEHN
4. DATE OF DEATH Month 8 Day 29 Year 57
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 7-12-93
9. AGE (In years last birthday) 64 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN
10b. KIND OF BUSINESS OR INDUSTRY US GOVERNMENT
11. BIRTHPLACE (City and state or country) MASCOUTAH, ILLINOIS
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FRANK KUEHN
14. MOTHER'S MAIDEN NAME MARGARET SCHAEFFER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT VA HOSPITAL RECORDS, ST. LOUIS, MISSOURI Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS — INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 002X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
GENERALIZED ARTERIOSCLEROSIS, CEREBRAL HEMORRHAGE
19. WAS AUTOPSY PERFORMED? YES X NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ NONE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. VA attended the deceased from 6-8-57 to 8-29-57 and last saw him alive on 8-29-57
Death occurred at 6:30 P m on the date stated above; and to the best of my knowledge, from the causes stated
22a. SIGNATURE J. E. Westphaelinger (Degree or title) M. D.
22b. ADDRESS VAH, ST. LOUIS, MISSOURI
22c. DATE SIGNED 8-29-57

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 8-30-57
23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT
23d. LOCATION (City, town, or county) BELLEVILLE ILL (State)
24. FUNERAL DIRECTOR RENNER ADDRESS BELLEVILLE ILL.
25. DATE RECD. BY LOCAL REG. AUG 30 57
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually 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 em

by me, or by Not Embalmed, Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed Geo Renner

Licensed Embalmer No. 23

P. O. Address Bellevu

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.