

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023475
State File No.

FILED JUL 14 1958

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 6788

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 5 mo. 7 days	c. CITY OR TOWN St. Louis
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis Chronic Hospital		e. STREET ADDRESS (If rural, give location) 3127 Locust	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) c. (Last) Koons		4. DATE OF DEATH (Month) (Day) (Year) June 28, 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH May 4, 1869
9. AGE (In years last birthday) 89	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	11. BIRTHPLACE (City and State or Foreign Country) Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Silas Koons		13b. MOTHER'S MAIDEN NAME Mary Koons	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS St. Louis Chronic Hospital Records 5600 Arsenal St.
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) <i>Central Arteriosclerosis</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Terminal Bronchopneumonia</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 334x	20. AUTOPSY? 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)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
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 Jan. 21, 1958, to June 28, 1958, that I last saw the deceased alive on June 28, 1958, and that death occurred at 8:30 P.M., from the causes and on the date stated above.
23a. SIGNATURE <i>George M. Janaka, M.D.</i> (Degree or title)		23b. ADDRESS 5800 Arsenal	23c. DATE SIGNED 6/30/58
24a. BURIAL, CREMATION, REMOVAL removal	24b. DATE 7-8-58	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	24d. LOCATION (City, town, or county) (State) Belleville, Illinois
DATE REC'D BY LOCAL REG. JUL 8 '58	REGISTRAR'S SIGNATURE <i>J. Paul Smith, M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Nell Walsh Barnes E. St. Louis, Illinois	

(Licensed Embalmer's Statement on Reverse Side)

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.....
P. O. Address.....
East St. Louis
Ill.

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.