

Health, Welfare  
Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046590

STATE FILE NUMBER

FILED DEC 22 1958 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3246

300  
-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Clayton</b> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kirkwood 4703</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>St. Louis County Hosp.</b> INSTITUTION		Length of stay in 1b <b>20 days</b>	d. STREET ADDRESS (If outside, give location) <b>711 S. Kirkwood Rd</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Louisa</b> First <b>Kuntz</b> Middle Last			4. DATE OF DEATH <b>12 10 58</b> Month Day Year		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1861</b>		9. AGE (In years last birthday) <b>96</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never worked</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Martin Kuntz</b>		13b. MOTHER'S MAIDEN NAME <b>Katherine Werner</b>		14. NAME OF HUSBAND OR WIFE <b>Single</b>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Old Folks Home Records, Kirkwood, Mo.</b> Address
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Pulmonary edema</b>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Fracture, prof 1/2, Rt femur, post-operative</b>		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 Month, Day, Year a.m. p.m.		

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	COUNTY	STATE
--	--	------------------------------	--------	-------

21. I attended the deceased from **11-21-58** to **12-10-58** and last saw her alive on **12-10-58**  
Death occurred at **10:30 P** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Vernon J. Frazier MD</b>	22b. ADDRESS <b>601 So. Brentwood</b>	22c. DATE SIGNED <b>12/17/58</b>
---	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/13/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
--	------------------------------	--	---

24. FUNERAL DIRECTOR <b>Louis H. Hoffm. - Kirkwood</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-12-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>
--	---	---

(L) Embalmer's Statement on Reverse Side

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

**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 *Francis J. Myland Jr* .....

Licensed Embalmer No. *4512* .....

P. O. Address *Hickwood, Mo* .....

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.