THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003984
STATE FILE NUMBER

FILED FEB 11 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 334

1. PLACE OF DEATH a. COUNTY St. Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch, Missouri — Inside Limits Yes ☐ No ☒	c. CITY OR TOWN St. Louis 2 1 9 9 — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Robert Koch Hosp. — Length of stay in 1b 6 days	d. STREET ADDRESS (If outside, give location) 4345 Washington — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First JOHN Middle Last HUNT		4. DATE OF DEATH Month Jan. Day 30 Year 1959	
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH 11-5-08
9. AGE (In years last birthday) 50	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) Laborer	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) Mississippi	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Hunt		14. MOTHER'S MAIDEN NAME Maggie Armstrong	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -	16. SOCIAL SECURITY NO. -	17. INFORMANT Address Koch Hospital records, Koch, Mo.	

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) Massive hemoptysis — INTERVAL BETWEEN ONSET AND DEATH ?

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Pulmonary tuberculosis
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)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. I attended the deceased from 1-24-59, to 1-30-59 and last saw her/him alive on 1-30-59
Death occurred at 11:00 Am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Bernard Friedman, M.D.	22b. ADDRESS Robert Koch Hospital, Koch Mo.	22c. DATE SIGNED 1-30-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-4-59	23c. NAME OF CEMETERY OR CREMATORY Father Dickson
23d. LOCATION (City, town, or county) (State) Kirkwood, Mo.		
24. FUNERAL DIRECTOR ADDRESS H L BEAKUND CO 4303 Delmar	25. DATE RECD. BY LOCAL REG. 2-2-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 2

P. O. Address ..... Cit

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.