

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011111-11
STATE FILE NUMBER
2 3072

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 5170 Rosa Ave.		d. STREET ADDRESS (If outside, give location) 5170 Rosa Ave.	

3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM J. KUSSMAN			4. DATE OF DEATH Month Day Year Mar. 24 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1887	9. AGE (In years last birthday) 71	10. FUNDER 1 YEAR Months Days	11. IF 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) Inspector (Retired)	10b. KIND OF BUSINESS OR INDUSTRY Samuel Shoe Co.	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Christopher Kussman	13b. MOTHER'S MAIDEN NAME Margaret Rembold	14. NAME OF HUSBAND OR WIFE -----
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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) No	16. SOCIAL SECURITY NO. 488-03-9318	17. INFORMANT Address Gertrude Wilson 5170 Rosa Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocarditis		INTERVAL BETWEEN ONSET AND DEATH 2 days
DUE TO (b) Chronic myocarditis (present)		
DUE TO (c) arteriosclerotic heart disease present		6-6-58
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) arthritic dorsal spine & marked Kyphosis		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.) 420.0
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.) 9-4-53	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from Death occurred at 10:30 P. on 9-4-53 to 3-24-59 and last saw her alive on 3-21-59 him
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22a. SIGNATURE (Degree or title) John T Flynn BSMD	22b. ADDRESS 1715 So 39th St Kansas Mo	22c. DATE SIGNED 3-26-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Mar. 28, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway	25. DATE RECD. BY LOCAL REG. MAR 26 '59	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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1-57
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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 *Edwin A. McKeen*

Licensed Embalmer No. *3024*

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.