

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022172

STATE FILE NUMBER

Health,
Welfare
Public
Service

FILED JUN 25 1959 Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 180

1. PLACE OF DEATH a. COUNTY MARION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY PIKE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HANNIBAL		c. CITY OR TOWN FRANKFORD	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LEVERING HOSPITAL		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) CLARENCE B. KUNTZ		4. DATE OF DEATH JUNE 21 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 13 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 59
13. FATHER'S NAME JOHN KUNTZ		14. MOTHER'S MAIDEN NAME FLONELIA COOPER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO YES		17. INFORMANT MRS. C. B. KUNTZ, FRANKFORD, MO	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 <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 _____ 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 6/15/59 to 6/21/59 and last saw her/him alive on 6/20/59 Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature]	22b. ADDRESS 2910 St. Mary's Ave. Hannibal, Mo.	22c. DATE SIGNED 6/22/59	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE JUNE 23 '59	23c. NAME OF CEMETERY OR CREMATORY BOWLING GREEN CEMETERY	23d. LOCATION (City, town, or county) (State) BOWLING GREEN, MO
24. FUNERAL DIRECTOR GRACE BANKHEAD		25. DATE RECD. BY LOCAL REG. 6-22-59	
26. REGISTRAR'S SIGNATURE [Signature]			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

DATE FILED JUN 24 1951

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 *Harold Kink*.....

Licensed Embalmer No. *459*

P. O. Address *Bowling Green*

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.