

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022807

FILED JUL 1 1959 Registration District No. Primary Registration District No. STATE FILE NUMBER 5653 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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5117 Westminster		Length of stay in 1b. Life	d. STREET ADDRESS (If outside, give location) 5117 Westminster Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last
Lottie Helen Cuntz

4. DATE OF DEATH Month Day Year
June 13, 1959

5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1891	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days	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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown McCullup	14. NAME OF HUSBAND OR WIFE Frederick Cuntz
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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. -	17. INFORMANT Address Mrs. Charles Cuntz, 5117 Westminster Place
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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) Arterio Sclerotic Heart Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio Sclerosis
DUE TO (c) 420.0
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 <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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from _____ to _____ and last saw her alive on _____
Death occurred at _____ on the date stated above; and to the best of my knowledge from the causes stated.

22a. SIGNATURE <i>Regina J. ...</i>	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 6/15/59
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23a. BURIAL, CREMATION, OR OTHER DISPOSITION Burial	23b. DATE June 16, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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24. FUNERAL DIRECTOR <i>Arthur J. Nonnelly</i>	ADDRESS 840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. JUN 15 '59	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 William*

Licensed Embalmer No. *356*

P. O. Address *3840 Fen*

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.