

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023301

STATE FILE NUMBER 2 5583

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

FILED JUN 24 1959

1. PLACE OF DEATH a. COUNTY		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 ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP.		d. STREET ADDRESS (If outside, give location) 3424 1/2 WINNEBAGO	
3. NAME OF DECEASED (Type or print) First MIDDLE LAST AUGUST C. PUHL		4. DATE OF DEATH Month Day Year JUNE 9, 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 14 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED NIGHT WATCHMAN		10b. KIND OF BUSINESS OR INDUSTRY CITY HALL	11. BIRTHPLACE (City and state or country) MISSOURI
13a. FATHER'S NAME EDWARD PUHL		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE AGNES PUHL
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. 489-05-2038	17. INFORMANT Address AGNES PUHL 3424 1/2 WINNEBAGO
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Branchiogenic Carcinoma of Rt. lung with</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <i>162-1</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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 <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 <i>4/6/59</i> to <i>6/9/59</i> and last saw ^{her} _{him} alive on <i>6/9/59</i> Death occurred at <i>11:15 A.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John Q. Chapman M.D.</i>		22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 6/9/59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JUNE 12 1959	23c. NAME OF CEMETERY OR CREMATORY ST. PETER & PAUL CEM.	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO
24. FUNERAL DIRECTOR ADDRESS <i>Thomas Kutis 2906 Gravois</i>		25. DATE RECD. BY LOCAL REG. JUN 11 '59	26. REGISTRAR'S SIGNATURE <i>Neal Smith, M.D.</i>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
300
57
26
4
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.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

G.P.

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 James C. Hill _____

Licensed Embalmer No. 4347
P. O. Address 2906 Howard

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.