

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026997

FILED JUL 17 1959

Primary Registration District No.

Registrar's

2 6370

STATE FILE NUMBER

DED

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		Length of stay in 1b		c. CITY OR TOWN St Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3310 Magnolia			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3310 Magnolia		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle MUNTZEL Last				4. DATE OF DEATH Month July Day 4 Year 1959				
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-6-1874	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
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) Missouri		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME Lorenz Anderlini			13b. MOTHER'S MAIDEN NAME Magdalene Schaefer			14. NAME OF HUSBAND OR WIFE Julius Muntzel 'Dec		
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 Magdalene Mertens Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carotid Artery Stenosis							INTERVAL BETWEEN ONSET AND DEATH 60 years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Senile Arterio Sclerosis								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year								
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 1944 to July 4-59 and last saw her alive on July 4-59 Death occurred at 9:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) H Louis Schuchert M.D.				22b. ADDRESS 3066 Delora Place		22c. DATE SIGNED July 6-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 8 1959	23c. NAME OF CEMETERY OR CREMATORY SS Peter and Paul Cem		23d. LOCATION (City, town, or county) St Louis MO		(State)		
24. FUNERAL DIRECTOR Thomas Kutis ADDRESS 2906 Gravois			25. DATE RECD. BY LOCAL REG. JUL 6 '59		26. REGISTRAR'S SIGNATURE Loard Smith, M.D. <i>mjb</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Miss Alice A. Thomas

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Eleanora*

Licensed Embalmer No. *3403*

P. O. Address *2906 Row*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.