

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS OCT 8 1959

59-034007

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 8916**

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|---|---|---|---|
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3711 Salena St | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 3711 Salena St | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|-------------------------------------|--------------------|--------------------|-----------------------|------------------|----------------|---------------|------------------|
| 3. NAME OF DECEASED (Type or print) | First FRANK | Middle JOHN | Last KUTNOHORS | 4. DATE OF DEATH | Month 9 | Day 26 | Year 1959 |
|-------------------------------------|--------------------|--------------------|-----------------------|------------------|----------------|---------------|------------------|

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|--------------------|-------------------------------|--|----------------------------------|--------------------------------------|-----------------|----------------|
| 5. SEX Male | 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 9-9-1872 | 9. AGE (last birthday) 87 Yrs | IF UNDER 1 YEAR | IF UNDER 24 HR |
| | | | | Months | Days | Hours Min. |

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter | 10b. KIND OF BUSINESS OR INDUSTRY | 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 Unknown | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Deceased |
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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. 494-05-5283 | 17. INFORMANT Raymond Kutner Address 9438 Brenda Affton Mo |
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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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Uremia | | 5 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Cardio renal - vascular Disease | years |
| | DUE TO (c) Arteriosclerosis, generalized | years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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.) 442x |
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| | | |
|---------------------|----------------------------|------------------------|
| 20c. TIME OF INJURY | Hour _____ a.m. _____ p.m. | Month, Day, Year _____ |
|---------------------|----------------------------|------------------------|

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|--|--|------------------------------|--------|-------|
| 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 **9-22-59** to **9-26-59** and last saw ^{her}him alive on **9-25-59**
 Death occurred at **7:00 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE Geo. A. Seib M.D. (Degree or title) | 22b. ADDRESS 2323 Lafayette St Louis | 22c. DATE SIGNED 9-28-59 |
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|--|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) cremation | 23b. DATE 9-29-1959 | 23c. NAME OF CEMETERY OR CREMATORY Missouri Crematory | 23d. LOCATION (City, town, or county) (State) 3711 Sublette Ave MO |
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| 24. FUNERAL DIRECTOR Jegenheim Bros. ADDRESS 6409 Gravois Av | 25. DATE RECD. BY LOCAL REG. SEP 28 59 | 26. REGISTRAR'S SIGNATURE Carl Smith, M.D. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Paul M. Signore

Licensed Embalmer No. 4343

P. O. Address St. Louis, Mo

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.