URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-008487

FILED VS MAR 7 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1726 STATE FILE NUMBER

NDED

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 Mo | Length of stay in 1b

c. CITY OR TOWN ST. LOUIS | Inside Limits Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ALEXIAN BROS. Hosp. | Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 3744 S. COMPTON | Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First JOHN Middle KUHN Last

4. DATE OF DEATH Month FEB. Day 11 Year 1960

5. SEX MAle

6. COLOR OR RACE WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH JULY 29 1888

9. AGE (last birthday) 71 | 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) RETIRED WELDER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) AUSTRIA HUNGARY

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME JOHN KUHN

13b. MOTHER'S MAIDEN NAME ANNA HASSETT

14. NAME OF ~~HUSBAND~~ OR WIFE KATI KUHN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT KATI KUHN Address 3744 S. COMPTON

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Generalized Arteriosclerosis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) with senility

DUE TO (c) 450.0

INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 2-1-60 to 2-11-60 and last saw ~~her~~ him alive on 2-10-60

Death occurred at 10 45 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Louis T Lihon MD.

22b. ADDRESS 634 N. Grand Ave. St. Louis 3, Mo.

22c. DATE SIGNED FEB. 13, 1960

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE FEB. 15 1960

23c. NAME OF CEMETERY OR CREMATORY S.S. PeTER + PAUL

23d. LOCATION (City, town, or county) ST. LOUIS (State) Mo

24. FUNERAL DIRECTOR Thomas Kutis ADDRESS 2906 Gravois

25. DATE RECD. BY LOCAL REG. FEB 15 1960

26. REGISTRAR'S SIGNATURE Carl Smith. M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

P.A. 619

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906

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