

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021178

FILED VS MAY 23 1960

2 4365

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Kirkwood	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hamilton Med. Center		d. STREET ADDRESS (If outside, give location) IIOI Whitecliff Dr.	
3. NAME OF DECEASED (Type or print) ELIZABETH		4. DATE OF DEATH April 21 1960	
5. SEX Female		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 5/12/1879	
9. AGE (last birthday) 80		IF UNDER 1 YEAR IF UNDER 24 HR Months Days 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 AT NONE	
11. BIRTHPLACE (City and state or country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME George Laffer		13b. MOTHER'S MAIDEN NAME Mary Laudon	
14. NAME OF HUSBAND OR WIFE Ralph J Kunz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Ralph J Kunz IIOI Whitecliff Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction - 7 hours DUE TO (b) Arteriosclerotic Heart Disease Several yrs DUE TO (c) 4200 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senile Pulmonary Emphysema			
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 checked="" type="checkbox"/> NO <input 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 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 3-11-59 to 4-21-60 and last saw her alive on 4-8-60 Death occurred at 12:20 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) A.J. Steiner MD		22b. ADDRESS 3720 Washington Ave	
22c. DATE SIGNED 4-22-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 23 1960	
23c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery		23d. LOCATION (City, town, or county) St. Louis Mo. (State)	
24. FUNERAL DIRECTOR R. Lupton and Sions 7233 Delmar		25. DATE RECD. BY LOCAL REG. APR 22 1960	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Clarence H. Miller

Licensed Embalmer No. 4011
P. O. Address H. Louis

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