RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED/VS JUN 20 1960 — Registrar's District No. 317 — Primary Registration District No. 541 — Registrar's No. 1730 — -60-025220 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY: ST LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: CLAYTON — Length of stay in 1b: 2 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS COUNTY HOSPITAL — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI — b. COUNTY: ST LOUIS
c. CITY OR TOWN: FENTON — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): R.R. #1 BOX 337 — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: L. — Last: KUEHN

4. DATE OF DEATH: Month: JUNE — Day: 1 — Year: 1960

5. SEX: MALE

6. COLOR OR RACE: CAUCASIAN

7. Married ☒ **Never Married** ☐ **Widowed** ☐ **Divorced** ☐

8. DATE OF BIRTH: 1/9/1877

9. AGE (last birthday): 83 — 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): CUSTODIAN (RETIRED)

10b. KIND OF BUSINESS OR INDUSTRY: PUBLIC SCHOOL

11. BIRTHPLACE (City and state or country): ST. LOUIS, MISSOURI

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: (UNKNOWN)

13b. MOTHER'S MAIDEN NAME: (1st UNKNOWN) WEMPNER

14. NAME OF HUSBAND OR WIFE: PAULINE KUEHN

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.: NONE

17. INFORMANT: MR. RAYMOND A. KUEHN, 6039 CHILDRESS — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ~~Arteriosclerotic heart~~ disease — INTERVAL BETWEEN ONSET AND DEATH: yrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
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. ☐ 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 5-21-60, to 5-28-60 and last saw him alive on 5-28-60
Death occurred at 1:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Arthur W Westruf M.D.

22b. ADDRESS: 8540 Big Bend

22c. DATE SIGNED: 6-2-60

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

23b. DATE: 6/3/1960

23c. NAME OF CEMETERY OR CREMATORY: ST. PETERS CEMETERY

23d. LOCATION (City, town, or county) (State): ST. LOUIS COUNTY, MISSOURI

24. FUNERAL DIRECTOR — ADDRESS: HOFFMEISTER COLONIAL MORTUARY, 6464 CHIPPEWA STREET ST. LOUIS, MISSOURI

25. DATE RECD. BY LOCAL REG.: 6-2-60

26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT — 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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.