

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 9 1961 318

Primary Registration District No. 1003

Registrar's No. 873

STATE FILE NUMBER -61-003322

AMENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Macoupin									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b		c. CITY OR TOWN Mt. Clare		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Box 64		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First CARRIE Middle ANNIS Last KULENKAMP				4. DATE OF DEATH Month JANUARY Day 27 Year 1961									
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 1/30/1897		9. AGE (last birthday) 63		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 At Home		11. BIRTHPLACE (City and state or country) Plainview, Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME Tom Taylor				13b. MOTHER'S MAIDEN NAME Grace Combs				14. NAME OF HUSBAND OR WIFE Roy Kulenkamp, St. Clare,					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil				16. SOCIAL SECURITY NO. None		17. INFORMANT Roy Kulenkamp, St. Clare, Illinois.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE										INTERVAL BETWEEN ONSET AND DEATH 2 MINUTES			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CRANIOTOMY, POST-OPERATIVE										3 DAYS			
DUE TO (c) RECURRENT INTRAVENTRICULAR TUMOR (? MENINGIOMA)										20 YEARS			
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. 223x <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 a.m. 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 MARCH 28, 1940 to JAN. 27, 1961 and last saw her/him alive on JAN. 27, 1961 Death occurred at 5:25 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>C. J. Amellia, M.D.</i> (Degree or title)						22b. BARNES HOSPITAL		22c. DATE SIGNED 1/28/61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1/28/61		23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) Shippman, Illinois.		(State)					
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 1700 Washington Blvd.,				25. DATE RECD. BY LOCAL REG. JAN 28 1961		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>							

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

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

Elmer R. Cadwell

Licensed Embalmer No. 4077

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.