

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-023508

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 17m

1. PLACE OF DEATH a. COUNTY <b>St. Louis County, Missouri</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis County, Clayton</b>		Length of stay in 1b <b>1 week</b>	c. CITY OR TOWN <b>MAPLEWOOD St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis County Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7271 A Southwest Ave.</b>
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Koontz</b> Last <b>Koontz</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/21/92</b>
9. AGE (last birthday) <b>68</b>		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) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	11. BIRTHPLACE (City and state or country) <b>Bunceton, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Joseph R. Koontz</b>	
13b. MOTHER'S MAIDEN NAME <b>Lida Funkha user</b>		14. NAME OF HUSBAND OR WIFE <b>Mary Koontz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>ww 1</b>	
17. INFORMANT <b>Betty Koontz Shephard</b>		Address <b>R 1 Labadie, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive, Hemorrhagic encephalomalacia (R. Ponsoldt)</b> <b>-temporal + occipital)</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral hemorrhage</b> DUE TO (c) <b>Hypertensive cardiovascular disease</b>			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) <b>Pulmonary infection, Gen. arteriosclerosis</b>			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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. 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.		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 <b>6-13-61</b> to <b>6-20-61</b> and last saw him alive on <b>6-20-61</b> Death occurred at <b>11:34</b> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Robert L. Howe M.D.</b>		22b. ADDRESS <b>601 S. Brentwood Clayton, Mo.</b>	
22c. DATE SIGNED <b>6/29/61</b>			
23a. BURIAL, CREMATION, or other disposition <b>REMOVAL</b>	23b. DATE <b>6/22/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bunceler Masonic Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Pilot Grove Mo.</b>
24. FUNERAL DIRECTOR <b>JAY B. SMITH</b>		ADDRESS <b>MAPLEWOOD MISSOURI</b>	25. DATE RECD. BY LOCAL REG. <b>6-21-61</b>
		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

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 Melvin Barton

Licensed Embalmer No. 4903

P. O. Address St. Louis

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.