

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10172

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. Length of stay in 1b _____
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6137 S. Grand Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY _____
c. CITY OR TOWN St. Louis Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 6137 S. Grand Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last Dr. Helmuth M. Kinner
4. DATE OF DEATH Month Day Year Oct. 31, 1961

5. SEX male **6. COLOR OR RACE** white **7. Married** **Never Married**
Widowed **Divorced**
8. DATE OF BIRTH Oct. 4, 1874 **9. AGE (last birthday)** 87
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) Physician-Surgeon
10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (City and state or country) St. Louis, Mo. **12. CITIZEN OF WHAT COUNTRY** USA

13a. FATHER'S NAME Hugo Kinner **13b. MOTHER'S MAIDEN NAME** Augusta Unk **14. NAME OF HUSBAND OR WIFE** Marie Kinner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no **16. SOCIAL SECURITY NO.** unk **17. INFORMANT** Marie Kinner 6137 S. Grand, Address _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO (b) and arteriosclerotic heart dis.
DUE TO (c) 491X

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

INTERVAL BETWEEN ONSET AND DEATH 2 wks

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 Oct 17 to Oct 31 and last saw her/him alive on Oct 31
Death occurred at 10 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ralph Berg MD (Degree or title) **22b. ADDRESS** 3203 S Grand **22c. DATE SIGNED** 11/1/61

23a. BURIAL, CREMATION, REMOVAL (Specify) removal **23b. DATE** 11-3-61 **23c. NAME OF CEMETERY OR CREMATORY** Sunset Burial Park **23d. LOCATION** (City, town, or county) St. Louis County, Mo. (State) _____

24. FUNERAL DIRECTOR Southern Funeral Home ADDRESS 6322 S. Grand, St. Louis, Mo. **25. DATE RECD. BY LOCAL REG.** NOV 1 1961 **26. REGISTRAR'S SIGNATURE** Loard Smith, M.D.

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

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 David Van Fossen

Licensed Embalmer No. 4543

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.