

# MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

FILED FEB 7 1962 318

1003

1394

=62-004028  
STATE FILE NUMBER

AMENDED

ST-27165 XC-572 525

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. CITY OR TOWN <u>CARLINVILLE</u>	
Length of stay in 1b <u>70 DAYS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VAH, 915 NO. GRAND AVE.</u>		d. STREET ADDRESS (If outside, give location) <u>703 JOHNSON STREET</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>HERMAN J. KEUNE</u>			4. DATE OF DEATH Month Day Year <u>1/31/62</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/8/89</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>CARLINVILLE, ILLINOIS</u>	
13a. FATHER'S NAME <u>HENRY A. KEUNE</u>		13b. MOTHER'S MAIDEN NAME <u>CATHERINE PEPPER</u>		14. NAME OF HUSBAND OR WIFE <u>LAURA PEARL KEUNE</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>LAURA PEARL KEUNE (WIDOW) SEE #2</u>	
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>ABOUT 8 HRS</u>	
DUE TO (b) <u>CHRONIC LYMPHATIC LEUKEMIA</u>		<u>ABOUT 3 YRS</u>	
DUE TO (c) <u>2040 F</u>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>FRACTURE LEFT HIP</u>			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		
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Fell at Veterans Hospital</u>			
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20c. TIME OF INJURY Hour Month, Day, Year s.m. p.m. <u>1-27-1962</u>					
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Vet. Hospital</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	COUNTY <u>Mo.</u>	STATE
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21. Attended the deceased from <u>11/22/61</u> to <u>1/31/62</u> and last saw him alive on <u>1/31/62</u> Death occurred at <u>2:50 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Arnold Goldman, Goldman M.D.</u>	22b. ADDRESS <u>VAH, ST. LOUIS, MO.</u>	22c. DATE SIGNED <u>1/31/62</u>
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23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>FEB 3, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CITY CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CARLINVILLE ILLINOIS</u>
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24. FUNERAL DIRECTOR <u>R. Butler</u>	25. DATE RECD. BY LOCAL REG. <u>FEB 1 1962</u>	26. REGISTRAR'S SIGNATURE <u>Loed Smith M.D.</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 TO BE CLEARED THRU CORONERS OFFICE  
 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 J. R. Butler, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed J. R. Butler  
Licensed Embalmer No. 5099 I

P. O. Address CARLINVILLE IL

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.