

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-008347

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **917**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 16 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY St. Louis, Mo.		b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis, Mo.		Length of stay in 1b 18 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair		c. CITY OR TOWN E. St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Childrens				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 2647 St. Clair St.				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ronnie Franklin Kuhn						4. DATE OF DEATH Month 1-21- Day 1962		5. SEX Male		6. COLOR OR RACE White	
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7-30-49		9. AGE (last birthday) 12 yr		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) E. St. Louis, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME John O. Kuhn				13b. MOTHER'S MAIDEN NAME Theresa Dye				14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address 500 S. Kingshighway y St. Vernell Kunzie					
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest Congestive Heart Failure Congenital Heart Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Congestive Heart Failure DUE TO (c) Congenital Heart Disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Acute Leukemia 754.5H								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"/> 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 1-3-62 to 1-21-62 and last saw her alive on 1-21-62 Death occurred at 5:10 am m on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE <i>Albert H. Chavanne MD</i> (Degree or title)		22b. ADDRESS Childrens Hospital		22c. DATE SIGNED 1-21-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 1-24-1962		23c. NAME OF CEMETERY OR CREMATORY Elk Cemetery		23d. LOCATION (City, town, or county) McArthur, Ohio		23e. (State)			
24. FUNERAL DIRECTOR Kurms Funeral Home ADDRESS E. St. Louis, Illinois				25. DATE RECD. BY LOCAL REG. JAN 22 1962		26. REGISTRAR'S SIGNATURE <i>Coal Smith, M.D.</i>					

USE BLACK INK OR TYPEWRITER RIBBON

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 Keith R. Savage Kerrick J. H.

Licensed Embalmer No. _____

P. O. Address _____

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.