

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6350-62-024846
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6350**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		c. CITY OR TOWN St. Louis	
Length of stay in 1b		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 CITY HOSP. #1.		d. STREET ADDRESS (If outside, give location) 2106 N. 13 th St.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY KUBE			4. DATE OF DEATH Month Day Year JUNE 26, 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-10-1886
9. AGE (last birthday) 75		10. BIRTHPLACE (City and state or country) Indiana	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. CITIZEN OF WHAT COUNTRY U. S. A.	
12. IF UNDER 1 YEAR Months Days		12. IF UNDER 24 HR Hours Min.	
13a. FATHER'S NAME Unknown Gavin		13b. MOTHER'S MAIDEN NAME Martha Adams	
14. NAME OF HUSBAND OR WIFE Carl Kube		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. INFORMANT Address Mr. Walter Murphy 4525a Fair		17. 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) Cerebral Vasculer Accident. DUE TO (c) 331X	
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. <input type="checkbox"/> Yes <input checked="" 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.	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 6/22/62 to 6/26/62 and last saw ^{her} _{him} alive on 6/26/62 Death occurred at 6:05 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John Mc Donough M.D.		22b. ADDRESS 1515 LAFAYETTE AVE	
22c. DATE SIGNED 6/26/62		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 6-28-62		23c. NAME OF CEMETERY OR CREMATORY Bethlehem Cem.	
23d. LOCATION (City, town, or county) St. Louis, Co., Mo.		(State)	
24. FUNERAL DIRECTOR Robert D. Kinealy		25. DATE RECD. BY LOCAL REG. JUN 27 1962	
ADDRESS 2228 St. Louis Ave.		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.	

MC DONOUGH
USE BLACK INK
OR
TYPEWRITER RIBBON

DATE AMENDED
VS 300 Rev. 4/59
1
2 **226**
3
4 **1**
5 **2**
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7 **1**
8 **1**
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12 **75-0**
13
75
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ
ITEM NO.
BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

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 Herbert J. Skiff

Licensed Embalmer No. 480

P. O. Address Kirkwood 22 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.