

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21888

State File No. 5136  
Registrar's No.

BIRTH NO. 38677-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Missouri b. COUNTY |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis                               |  |
| c. LENGTH OF STAY (in this place) LIFE   |  | d. STREET ADDRESS (If rural, give location) 2-3-1609 Menard Street   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Josephine Heitkamp Mem.                        |  |  |  |

|   |  |                        |                                   |  |  |   |  |   |                              |                         |                         |        |
|---|--|------------------------|-----------------------------------|--|--|---|--|---|------------------------------|-------------------------|-------------------------|--------|
| 3. NAME OF DECEASED (Type or Print)   |  | a. (First) LARRY       |                                   | b. (Middle) KENNETH                                      |  | c. (Last) WITT                              |  | 4. DATE OF DEATH (Month) (Day) (Year) 6 12 49 |                              |                         |                         |        |
| 5. SEX Male   |  | 6. COLOR OR RACE white |                                   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 5 |  | 8. DATE OF BIRTH June 10-1949               |  | 9. AGE (In years last birthday) —             | IF UNDER 1 YEAR Months —     | IF UNDER 24 HRS. Days 2 | IF UNDER 2 HRS. Hours 3 | 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 (State or foreign country) 9 |  |   | 12. CITIZEN OF WHAT COUNTRY? |                         |                         |        |

|                                      |  |  |  |                             |  |
|--------------------------------------|--|--|--|-----------------------------|--|
| 13a. FATHER'S NAME Cleo Kenneth Witt |  | 13b. MOTHER'S MAIDEN NAME Etta Marie Broyles |  | 14. NAME OF HUSBAND OR WIFE |  |
|--------------------------------------|--|--|--|-----------------------------|--|

|  |  |                           |  |   |  |
|--|--|---------------------------|--|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO. — |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Obeo. K Witt 1609 MENARD ST |  |
|--|--|---------------------------|--|---|--|

|   |  |  |  |                         |  |  |  |
|---|--|--|--|-------------------------|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION  |  |                         |  | INTERVAL BETWEEN ONSET AND DEATH 39 hrs. |  |
| <p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p> |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage   |  | DUE TO (b) Severe labor |  |  |  |
|   |  | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.               |  | DUE TO (c)              |  |  |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. |  |                         |  |  |  |

|                        |  |                                  |  |  |  |   |  |
|------------------------|--|----------------------------------|--|--|--|---|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|------------------------|--|----------------------------------|--|--|--|---|--|

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)               |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 1609 Menard |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR? 7600                             |  |

22. I hereby certify that I attended the deceased from 6/10 1949, to 6/12, 1949, that I last saw the deceased alive on 6/12, 1949, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

|   |  |                         |  |                          |  |
|---|--|-------------------------|--|--------------------------|--|
| 23a. SIGNATURE (Degree or title) I. Heintzweyler M.D. |  | 23b. ADDRESS 2026 209th |  | 23c. DATE SIGNED 6/12/49 |  |
|---|--|-------------------------|--|--------------------------|--|

|  |  |                   |  |   |  |   |  |
|--|--|-------------------|--|---|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial |  | 24b. DATE 6-14-49 |  | 24c. NAME OF CEMETERY OR CREMATORY Mt. Hope |  | 24d. LOCATION (City, town, or county) (State) St. Louis County Mo |  |
|--|--|-------------------|--|---|--|---|--|

|                                      |  |  |  |   |  |
|--------------------------------------|--|--|--|---|--|
| DATE REC'D BY LOCAL REG. JUN 14 1949 |  | REGISTRAR'S SIGNATURE J. O. S. Pasater |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Allen N. M. Kunklin 2301 Delphette |  |
|--------------------------------------|--|--|--|---|--|

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 .....  
Student Embalmer

Signed.....

*C W Cooper*

Licensed Embalmer No. *3850*

P. O. Address *2301 N. Fayette*

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 this body is not embalmed, fact should be so stated above.