

Health, Welfare, Public Services
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 1-56
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED MAY 20 1957

18564
 STATE FILE NUMBER
 3853
 Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN MISSOURI ST. LOUIS PINE LAWN 4151 Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 32 ST. LUKES HOSP				Length of stay in 1b 3 WKS		d. STREET ADDRESS (If outside, give location) 27 4305 BEACHWOOD Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Leo (NME) Cundiff				4. DATE OF DEATH Month Day Year April 22 1957			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 20 1903	
9. AGE (In years last birthday) 53				IF UNDER 1 YEAR Months Days Hours Min. 10 2		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, seen if retired) ELECTRICIAN				10b. KIND OF BUSINESS OR INDUSTRY BELL TELEPHONE		11. BIRTHPLACE (City and state or country) SILOAM SPRINGS, ARK, U.S.	
13. FATHER'S NAME SHERMAN CUNDIFF				14. MOTHER'S MAIDEN NAME MARY JONES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO				16. SOCIAL SECURITY NO. 488-07-596		17. INFORMANT Mrs. Mary Lela Cundiff Address 4305 Beachwood	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Chronic Lung disease DUE TO (c) old T.b.c. .002x CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tuberculous cystitis with perforation Antetental obt							INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs " "
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 Month, Day, Year 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 4/1/57 to 4/21/57 and last saw him alive on 4/21/57 Death occurred at 4:45 m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Richard B. Windsor M.D.				22b. ADDRESS St. Lukes Hospital		22c. DATE SIGNED 4/22/57	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-25-57		23c. NAME OF CEMETERY OR CREMATORY LAKE CHARLES CEM		23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY - MO	
24. FUNERAL DIRECTOR L. B. TANNER, 619 National Bldg			25. DATE RECD. BY LOCAL REG. APR 23 '57		26. REGISTRAR'S SIGNATURE J. Carl... mo		

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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
Signature of Student Embalmer

Signed *J. W. Pinkley*
Licensed Embalmer No. *365*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.