

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005044

FILED MAR 3 - 1958

STATE FILE NUMBER

Registration District No. 118 Primary Registration District No. 5439 Registrar's No. 8

300
-57

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Canaan Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Owensville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Farm Home</u>		Length of stay in lb <u>9 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>Route 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Leslie</u> Last <u>Cundiff</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>17,</u> Year <u>1958</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>Dec. 11, 1886</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired shoe worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>shoe industry</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>George Cundiff</u>		13b. MOTHER'S MAIDEN NAME <u>Geneva Mary Harris</u>		14. NAME OF HUSBAND OR WIFE <u>Jennie Graves Cundiff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>492-12-0167</u>		17. INFORMANT Address <u>Mrs. Jennie Cundiff Owensville, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial Degeneration.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>					<u>5 yrs.</u>
DUE TO (c) <u>443x</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Right Hemiplegia Due To Hypertension</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <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 <u>10-16-57</u> to <u>2-17-58</u> and last saw ^{him} alive on <u>2-17-58</u> Death occurred at <u>9 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Paula Brunner, M.D.</u> (Degree or title)			22b. ADDRESS <u>Owensville, Mo.</u>		22c. DATE SIGNED <u>2-21-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>2-20-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Owensville, Mo.</u>
24. FUNERAL DIRECTOR <u>Wilford H H White</u> ADDRESS <u>Owensville</u>			25. DATE RECD. BY LOCAL REG. <u>February 20, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Marvyn Jappmeyer</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc.: must use only standard nomenclature. All diseases in Part I must be causally related.

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 *Me*....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Michael H N White*.....

Licensed Embalmer No. 3838
P. O. Address OWEN SUHL.....

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.