

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045344

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11607

STATE FILE NUMBER

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1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St. Louis</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Louis</u>		c. CITY OR TOWN <u>Sullivan</u>	
Length of stay in lb <u>3 1/2 Days</u>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Lukes Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>111 Modern</u>	
Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last <u>RUSSELL L. CUNEIO</u>		Month Day Year <u>November 22 1963</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>6/19/15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>	9. AGE (last birthday) <u>48</u>
11a. BIRTHPLACE (City and state or country) <u>Tea, Missouri</u>		11. BIRTHPLACE (City and state or country) <u>Tea, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James Cuneio</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Bell</u>	
14. NAME OF HUSBAND OR WIFE <u>Mary L. Cuneio</u>		14. NAME OF HUSBAND OR WIFE <u>Mary L. Cuneio</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) <u>Yes W.W. #2</u>		17. INFORMANT <u>Mary Cuneio - Sullivan, Missouri</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		<u>48 hours</u>	
IMMEDIATE CAUSE (a) <u>Thrombosis BASILAR ARTERY</u>			
DUE TO (b) <u>ARTERIOSCLEROSIS -</u>			
DUE TO (c) <u>332x</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)		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 <u>9</u> a.m. <u>20</u> Month, Day, Year <u>Nov 20 1963</u> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>Sullivan</u> COUNTY <u>Franklin</u> STATE <u>Missouri</u>
21. I attended the deceased from <u>Nov 20</u> to <u>Nov 22 1963</u> and last saw her/him alive on <u>Nov 20 - 1963</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 (Degree or title) <u>Dr. George S. Stewart, M.D.</u>		22b. ADDRESS <u>3720 Washington, St. Louis</u>	22c. DATE SIGNED <u>Nov 23, 63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/26/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>	23d. LOCATION (City, town, or county) <u>Sullivan Missouri</u>
24. FUNERAL DIRECTOR <u>Memorial Funeral Home - Sullivan</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 25 1963</u>	26. REGISTRAR'S SIGNATURE <u>Roald Smith, M.D.</u>

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF MEDICAL CERTIFICATION DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

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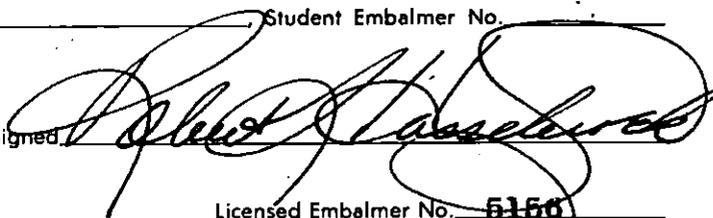
JAN 15 1964

MISSOURI
DEPARTMENT OF HEALTH

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 

Licensed Embalmer No. 5156

P. O. Address Sullivan, Missouri

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.