

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-049356

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **13029** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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		Length of stay in 1b 1 MONTH	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PARK LANE MEMORIAL HOSP.		d. STREET ADDRESS (If outside, give location) 101 1/2 LOCUST	
3. NAME OF DECEASED (Type or print) First Middle Last ANTHONY A. CUNEO		4. DATE OF DEATH Month Day Year 12 29 1963	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-9-85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHEET METAL WORKER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI
13a. FATHER'S NAME JOHN B. CUNEO		13b. MOTHER'S MAIDEN NAME CAROLINE (UNKNOWN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT LOUIS CHIONI 2921 MONTEAU DR.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Myocarditis Conditions, if any, which gave rise to above cause (e), stating the underlying cause last. DUE TO (b) 422.21 DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
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 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. Month, Day, Year		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 11-16-63 to 12-29-63 and last saw her/him alive on 12-29-63 Death occurred at 12:35 P on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS 4930 Lindell	
22c. DATE SIGNED 12-30-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC. 31, 1963	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	
24. FUNERAL DIRECTOR ARTHUR J DONNELLY 3840 LINDELL BLVD.		26. REG. AR'S SIGNATURE <i>[Signature]</i>	

USE BLACK INK OR TYPEWRITER RIBBON

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. 4699

P. O. Address. 3840 Lehigh

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.