

REC'D FEB 10 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

932  
Do not use this space.

## 1. PLACE OF DEATH

(a) County..... Registration District No. **791**  
(b) Township..... Primary Registration District No. **1003**  
(c) City **St. Louis** (d) Street No. **Missouri Baptist Hospital** Registered No. **932**  
(e) Length of residence in city or town where death occurred **50** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **William Henry Hunn**

(a) Residence, No. **6725a Hoffman Ave.** St. **3** (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Melrose Hunn**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 25th, 1858**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**80 8 4**

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Wis.**13. NAME **Wm. H. Hunn.**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **N.Y.**15. MAIDEN NAME **Dont Know**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ills.**17. INFORMANT (ADDRESS) **Mary Hunn, 6725a Hoffman Ave.**18. BURIAL, CREMATION, OR REMOVAL PLACE **Kansas City, Mo.** DATE **1-31-39**19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Provost Und. Co. 3710 N. Grand**20. FILED **J. P. Brudick** Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1-29-39**, 19**39**

22. I HEREBY CERTIFY, That I attended deceased from **Jan 29th, 1939** to **Jan 29th, 1939**  
I last saw him alive on **11:20 P.M. Jan 28, 1939**. Death is said to have occurred on the date stated above, at **6:30 A.M.**

The principal cause of death and related causes of importance were as follows:

Date of onset **9 hrs****Postoperative shock**

Other contributory causes of importance:

**Concussion of sigmoid colon** **12-20-37**Name of operation **Colostomy** Date of **12-19-37**What test confirmed diagnosis? **Laboratory** Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? **No**

If so, specify \_\_\_\_\_

(Signed) **Joseph M. Tress**, M. D.(Address) **818 Metropolitan Building**

JAN 30 1939

Tom. In 58  
Metropolitan Bldg  
1-3

**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, .....

A. A. Smithers.

or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

A. A. Smithers

Licensed Embalmer No. 3916

P. O. Address 3710 N. Grand Blvd.

**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, above space should be left blank.**