

DEC'D MAR 13 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH791  
1003

4635

Do not use this space.

## 1. PLACE OF DEATH

(a) County..... Registration District No.....  
 (b) Township..... Primary Registration District No..... Registered No. **1328**  
 (c) or City **St. Louis** (d) Street No. **Lutheran Hospital** St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **William Huning**

(a) Residence, No. **3539 Juniata** St. **16**  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Clara Huning**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 26 1880**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**58 8 15**

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Jeweler**  
 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 **16**

12. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) **Germany**13. NAME **Ernest Huning**14. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) **Germany**15. MAIDEN NAME **Augusta Scholle**16. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) **Germany**17. INFORMANT **Clara Huning**  
(ADDRESS) **3539 Juniata**18. BURIAL, CREMATION, OR REMOVAL PLACE **Sunset** DATE **Feb. 13**, 19 **39**19. FUNERAL DIRECTOR (NAME) **Wm. Schumacher**  
(ADDRESS) **3013 Meramec St.**20. FILED **FEB 10 1939** **J. E. Bricker** Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb. 10**, 19 **39**22. I HEREBY CERTIFY, That I attended deceased from **1-8-39**, 19, to **2-10-39**, 19I last saw him alive on **2-10-39**, 19. Death is said to have occurred on the date stated above, at **12:40 A.M.**

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

**Toxic Myelitis - Acute infection**Date of onset **1-7-39**

Other contributory causes of importance:

**Chronic Myocarditis**

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ 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? \_\_\_\_\_

If so, specify **Theo. H. Hansen, M. D.**  
(Signed) \_\_\_\_\_(Address) **3657 Grandel Blum**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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.....

*Clarence Pachow*....., Registered Apprentice No.  
.....working under my personal supervision.

Signed *Clarence Pachow*.....

Licensed Embalmer No. *3093*.....

P. O. Address *3013 Meram*.....

**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.**