

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.

AUG 11 1939

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

23644
Do not use this space.

1. CAUSE OF DEATH

(a) County **791 1008** Registration District No. _____
(b) Township _____ Primary Registration District No. _____ Registered No. **5917**
(c) City **St. Louis, Mo.** (d) Street No. **St. Ann's 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 **530 Stillborn Hunt**

(a) Residence, No. **5023 n. Kingshighway** St. **7** (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)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 3, 1939**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
0 0 0

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **0**
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) **St. Louis, Mo.**

FATHER 13. NAME **Albert Hunt**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

MOTHER 15. MAIDEN NAME **Ann Cassidy**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

17. INFORMANT **Albert L Hunt**
(ADDRESS) **5023 N. Kingshighway**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Valhalla Cem.** DATE **7-5 1939**

19. FUNERAL DIRECTOR (NAME) **Dickmann & Hann**
(ADDRESS) **1905 Union Blvd.**

20. FILED **JUL 5 1939** **J. B. Budek** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **7-3**, 19**39**

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h..... alive on _____, 19____. Death is said

to have occurred on the date stated above, at **11:59 P.m.**

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

Stillborn macerated fetus of about 16 1/2 mos. gestation. Date of onset

Other contributory causes of importance:

Name of operation **None** Date of _____

What test confirmed diagnosis? **All tests** Was there an autopsy? **NO**

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 _____

(Signed) **Henry J. Pango** M. D.

(Address) **634 Ch. Grand Ave.**

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

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

Signed.....

No Embalming
.....
Licensed Embalmer No.....

P. O. Address.....

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.