

Registration District No. 791

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis MO
(b) City or town St. Louis MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: CITY Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 DAYS
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

MINNIE LUNN

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

F

5. Color or race W

6. (a) Single, Married, Widowed, Divorced, Widowed

6. (b) Name of husband Deceased

6. (c) Age of husband at date of death Deceased

7. Birth date of deceased OCT 8 - 1887
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>52</u>	<u>0</u>	<u>18</u>	<u>by min.</u>

9. Birthplace

CHICAGO ILL
(City, town, or county) (State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER
12. Name (unk) WITTMAN
13. Birthplace GERMANY
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Dunn

(b) Address 3137 New Ashland

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof NOV 28 - 39
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Sullivan

(b) Address 2845 N. Euclid

19. (a) OCT 27 1939
(Date received local registrar)

(b) J. J. [Signature]
(Name of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City St. Louis 10
(If outside city or town limits, write "RURAL")
(d) Street No. 3137 New Ashland
(If rural, give location)
(e) If foreign born, how long in U. S. A. No Physician in Attendance years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 28
year 1939 hour 5:40 minute, A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage (Apoplexy)
contributed by
Due to: Cardiac Hypertrophy

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

Of autopsy: _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) _____
Means of injury _____

23. Signature Joseph M. Quinn (M. D. or other) _____
Address Deputy Coroner _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RGV 67-39
1 X19511

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

Henry Luvessis

Registered Apprentice No. *170*

working under my personal supervision.

Signed

Alban Mayfield
Henry Sullivan

Licensed Embalmer No. *2930*

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.