

Registration District No. 678

Primary Registration District No. 5904

Registrar's No.

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town St. James Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Soldiers Home Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 1 yr (Specify whether years, months or days) 3

3. (a) PRINT FULL NAME Oscar E. Hunge

3. (b) If veteran, name war World War 3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive. years

7. Birth date of deceased 9-15-1886
(Month) (Day) (Year)

8. AGE: Years 54 Months 2 Days 26 If less than one day hr. min.

9. Birthplace St. Paul Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Painter

11. Industry or business 9

12. Name Don't know 9

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name " " " "

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Record at Soldiers Home

(b) Address St. James mo

17. (a) Burial (b) Date thereof 12-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Paul, Missouri

18. (a) Signature of funeral director W.E. Reckleider

(b) Address St. James, Mo

19. (a) 12-12-40 (b) Elaine B. Hawk
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps
(c) City or town St James Mo
(If outside city or town limits, write "RURAL")
(d) Street No. Soldiers Home
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 16
year 40 hour 10:15 minute M.

21. I hereby certify that I attended the deceased from Dec 1
1940, to Dec 11, 1940
that I last saw him alive on Dec 11, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis

Due to _____
Due to _____ 9410

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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) (e) Means of injury _____

23. Signature W.E. Reckleider (M. D. or other) !
Address St James Mo Date signed 12-12-40

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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 *D. E. Kleber*

Licensed Embalmer No. 3546

P. O. Address St James

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.