

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 958

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch

(c) Name of hospital or institution: Robt Koch Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 22 1/2 Days
(Specify whether in this community _____ years, months or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 26105 COLE 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME DAVID JUNIOR HUNT

3. (b) If veteran, name war _____

3. (c) Social Security No. 488283763

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 28 year 46 hour 12 minute 35 pm

21. I hereby certify that I attended the deceased from 11 1945 to 4-28 1946
that I last saw him alive on 4-28 1946
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race C

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive 1 years 1 1927

7. Birth date of deceased (Month) (Day) (Year)

Immediate cause of death Chronic pul. The

Duration ?

8. AGE: Years 19 Months 4 Days 27 If less than one day hr. min.

Due to 13.5 1937
Due to to 1946

9. Birthplace Jackson, Miss (City, town, or county) (State or foreign country)

10. Usual occupation Shoe shiner

11. Industry or business _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

MOTHER FATHER

12. Name DAVID HUNT

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

14. Maiden name MARY WARREN

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant ROBT. KOCH HOSP.

(b) Address KOCH MO

17. (a) (b) Date thereof (Month) (Day) (Year)

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?

(c) Place: burial or cremation Wallerwood Cem

18. (a) Signature of funeral director A. E. Warren

(b) Address 2707 Grand St

19. (a) 5-2-46 (Date received local registrar) (b) E. D. McDaniel (Registrar's signature)

While at work? (Specify type of place) (c) Means of injury 0

23. Signature Paul S. Kouschek (M. D. or other) 0

Address Koch Hosp. - Koch, Mo Date signed 4/29/46

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

1550

16
0
0

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 *Arthur L. Hilliard*

Licensed Embalmer No. *4221*

P. O. Address *1154 Bayard a*

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, fact should be so stated above.