

No. 2  
-12-45  
-17-39  
X47070

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JAN 27 1947  
318

Registration District No. \_\_\_\_\_

Primary Registration District No. 100E

Registrar's No. 361

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Anthony Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 12 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

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

(d) Street No. 3723 Virginia Avenue  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Lena Wunsch

3. (b) If veteran, name war ---

3. (c) Social Security No. none

20. DATE OF DEATH: Month January day 10th  
year 1947 hour 8 minute 30 P.M.

4. Sex female 5. Color or race white

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

6. (b) Name of husband or wife August, Sr.

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

7. Birth date of deceased February 2nd, 1872  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-29-46  
to 1-11-47  
that I last saw her alive on 1-11-47  
and that death occurred on the date and hour stated above.

Immediate cause of death Coxsackie Oculum  
Duration 13 days

8. AGE: Years Months Days If less than one day

74	11	9	hr. min.
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Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Other conditions Cerebral Palsy  
(Include pregnancy within 3 months of death)

10. Usual occupation home

11. Industry or business \_\_\_\_\_

Major findings: none

12. Name Unknown

Of operations \_\_\_\_\_

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

Of autopsy above

14. Maiden name Unknown

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

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

16. (a) Informant Richard Wunsch

(b) Address 4501 Tennessee, St. Louis, Mo.

17. (a) entombment (b) Date thereof Jan. 13, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Mausoleum

18. (a) Signature of funeral director Hacker - Aldred & Co.

(b) Address 3634 Gravois, St. Louis, Mo.

19. (a) JAN 13 1947 (b) J. F. Brudick  
(Date received local registrar) (Registrar's signature)

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)

(7) Means of injury \_\_\_\_\_

23. Signature Joseph P. Gerny (M. D. or other) \_\_\_\_\_  
Address 10651-50 Grand Date signed 1-12-47

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 Robert C. Coker

Licensed Embalmer No. 2128

P. O. Address Spokane, Mo

**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.