

FILED JUN 20 1947

318

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

22353

1003

Registrar's No. 5956

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

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

1. PLACE OF DEATH:

(a) County St Louis  
(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 MARY'S INFIRMARY 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County 999  
(c) City or town EAST ST LOUIS 11  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4743 Piggott AVE 0  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME BENNIE LEE HUNT  
(b) If veteran, name war XXXXXXXXXXXX  
(c) Social Security No. XXXXXXXX

4. Sex MALE 2 5. Color or race Col  
6. (a) Single, widowed, married, divorced INFANT 0  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
(Day) (Year)

8. AGE: Years XX Months 9 Days 16  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace EAST ST LOUIS ILL 1  
(City, town, or county) (State or foreign country)

10. Usual occupation INFANT

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

MOTHER FATHER { 12. Name ALBERT HUNT  
13. Birthplace MONROE LA. 1  
(City, town, or county) (State or foreign country)  
14. Maiden name SARAH JANE SYKES  
15. Birthplace OKLOVA Miss 1  
(City, town, or county) (State or foreign country)

16. (a) Informant SARAH JANE HUNT  
(b) Address 4743 Piggott AVE

17. (a) BURIAL (b) Date thereof 6-20-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREENWOOD CEM.

18. (a) Signature of funeral director ELLIS FUNERAL HOME  
(b) Address 2820 STODDARD ST

19. (a) JUN 19 1947 (b) J. J. Brudeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17 year 1947 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from 6-17-47 to 6-17-47 that I last saw him alive on 6-17-47 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia Duration few days

Due to \_\_\_\_\_  
Due to 108  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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)  
(c) Means of injury \_\_\_\_\_

23. Signature John W. ... (M. D. or other) \_\_\_\_\_  
Address 1433 1/2 Bldg Date signed \_\_\_\_\_

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 Fulton E. Culkin  
Licensed Embalmer No. 4198  
P. O. Address Shorris 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.**