No. 2
1/47
17-39

2
8

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED SEP 16 1948
Registration District No. 310

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6067

State File No. 30754
Registrar's No. 173

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Charles County Home 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 years (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 92
(a) State Mo. (b) County St. Charles 0
(c) City or town St. Charles Mo. 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. -------- Rural
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Joe Hunicker
3. (b) If veteran, name war ------
3. (c) Social Security No. --------
4. Sex M D
5. Color or race W
6. (a) Single, widowed, married, divorced single D
6. (b) Name of husband or wife ---------
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Not known (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
about 80			hr. min.

9. Birthplace not known 9
(City, town, or county) (State or foreign country)
10. Usual occupation Farm labor 1
11. Industry or business -------
FATHER
12. Name not known
13. Birthplace " 9
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name "
15. Birthplace " 9
(City, town, or county) (State or foreign country)
16. (a) Informant Ben Orf
(b) Address O'Fallon M.
17. (a) burial (b) Date thereof 8-30-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation O'Fallon Mo.
18. (a) Signature of funeral director Eakerthly
(b) Address O'Fallon Mo.
19. (a) Aug 2-48 (b) Fannie Hamilton
(Date received local registrar) (Registrar's signature) 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 26
year 1948 hour 4 minute 15 P M.
21. I hereby certify that I attended the deceased from Aug 1st 1948 to Aug 26th 1948
that I last saw him alive on Aug 25th 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary occlusion	
Due to Chronic Myocardial insufficiency	
Due to Gen. Arteriosclerosis	
Other conditions — (Include pregnancy within 3 months of death)	
Major findings: Of operations —	
Of autopsy	

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature A P Erich Schulz M.D. (M. D. or other)
Address St Charles Mo. Date signed 9/1/48

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed SEP 10 1948

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 E. A. Keithly

Licensed Embalmer No. 822

P. O. Address O'Fallon 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.