

FILED APR 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13791
3341

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 1 Day		d. STREET ADDRESS (If rural, give location) 3611 Wyoming St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital			

3. NAME OF DECEASED (Type or Print) Loretta Z Gunn			4. DATE OF DEATH 4/12/49		
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 17th 1894	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months 8 Days 25	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME James Wines	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Clement T.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Nil	17. INFORMANT'S SIGNATURE OR NAME Clement T Gunn	ADDRESS 3611 Wyoming St
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 3 days Several years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Hypertension		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) 94 17301		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Feb. 19 1943** to **April 12, 1949**, that I last saw the deceased alive on **11/20, 1947**, and that death occurred at **8:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Edw. F. Sievers (Degree or title)	23b. ADDRESS 634 N. Grand Ave	23c. DATE SIGNED 4/15/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/15/49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemt.	24d. LOCATION (City, town, or county) (State) St. Louis Mo
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DATE REC'D BY LOCAL REG. APR 14 1949	REGISTRAR'S SIGNATURE J. B. Suster	DEPUTY FUNERAL DIRECTOR'S SIGNATURE Harrigan & Sheehan	ADDRESS 4415 Washington Blvd.
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

16

11-11
1930
4130
2706
penn

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Frank J. [Signature]

Signed _____
Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

*1255
S. [Signature]*

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.