

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10131**
Registrar's No. **2860**

FILED APR 12 1952

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BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis. 2709	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 2714 University St. 20	
3. NAME OF DECEASED (Type or Print) a. (First) MARGARET		b. (Middle)	
		c. (Last) HUNCKE	
4. DATE OF DEATH MARCH 25, 1952		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed <input checked="" type="checkbox"/>	
8. DATE OF BIRTH Aug. 26, 1878,		9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME John Deitl		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Late Henry C. Huncke		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Henry C. Huncke, 2714 University St.	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis, general		INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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)	
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 4570	

22. I hereby certify that I attended the deceased from **3-14-52**, 19___, to **3-25-52**, 19___, that I last saw the deceased alive on **3-25-52**, 19___, and that death occurred at **7:15A** m., from the causes and on the date stated above.

23a. SIGNATURE John T. Lawton, M.D. (Degree or title)		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 3-25-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 28, 1952		24c. NAME OF CEMETERY OR CREMATORY Valhalla Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		DATE REC'D BY LOCAL REG. MAR 26 1952		25. FUNERAL DIRECTOR'S SIGNATURE J. Carl Smith ADDRESS Reidner. Und. Co. 2223 St. Louis Av.	

WRITE PLAINLY—USING UNEADING 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.....

.....
working under my personal supervision.

..... Student Embalmer No.....

Signed.....
Student Embalmer

Signed

John P. Buckley

Licensed Embalmer No. *D 1674*

P. O. Address *2223 So. Lewis St.*

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.