

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40533

State File No.

FILED DEC 4 1953

Registrar's No. 11190

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File 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		c. LENGTH OF STAY (in this place) 1 week		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital				e. STREET ADDRESS (If rural, give location) 5 5100 Raymond			
3. NAME OF DECEASED (Type or Print) a. (First) Hettie			b. (Middle) A.		c. (Last) Gunther		4. DATE OF DEATH (Month) (Day) (Year) Nov. 24, 1953
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Aug. 31, 1882		9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and State or Foreign Country) Livingston County, Kentucky /		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME David Mitchell		13b. MOTHER'S MAIDEN NAME Nancy Edwards		14. NAME OF HUSBAND OR WIFE Lawrence Gunther			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Hettie Gunther, 5100 Raymond			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Fall on floor - fracture of hip</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>arteriosclerosis, Cardiac hypertrophy</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes - mellitus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
19a. DATE OF OPERATION <u>Nov 24-53</u>	19b. MAJOR FINDINGS OF OPERATION <u>Fracture of femur</u> (<u>OK P 271</u>)						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE <u>accidental</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis</u> <u>St. Louis</u> <u>MO</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Nov 17-53 about noon</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21f. HOW DID INJURY OCCUR? <u>Fall on floor</u> <u>E9030</u>	
22. I hereby certify that I attended the deceased from <u>Dec 2, 1952</u> to <u>Nov 24, 1953</u> , that I last saw the deceased alive on <u>Nov 24, 1953</u> , and that death occurred at <u>2:00 p. m.</u> , from the causes and on the date stated above. <u>20</u>							
23a. SIGNATURE (Degree or title) <u>Robert G. Warner MD</u>				23b. ADDRESS <u>Paul Brunner, 514 N. 2nd</u>		23c. DATE SIGNED <u>Nov 25-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE <u>Nov. 27, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Old Fellows Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Charleston, Missouri.</u>			
DATE REC'D BY LOCAL REG. <u>NOV 25 1953</u>		REGISTRAR'S SIGNATURE <u>Paul Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. Hoffmeister Colonial Mortuary</u> <u>6264 Chippewa St. St. Louis 9, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

Dr R. Tharner
5017 Donovan

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..

Student.....
Signature of Student Embalmer

Signed *Harry J. Schenck*.....

Licensed Embalmer No. *26.79*.....

P. O. Address *7814 S. Broadway*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.