

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2829

FILED FEB 4 1957

318

1003

State File No.

Registrar's No. 420

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		State File 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. LENGTH OF STAY (in this place township) 5 days		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 08 Deaconess Hospital 20690				* STREET ADDRESS (If rural, give location) 5228 Theodosia				
3. NAME OF DECEASED (Type or Print) a. (First) William		b. (Middle) S.		c. (Last) Hunt		4. DATE OF DEATH (Month) (Day) (Year) 1 13 57		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Oct. 23, 1883		
9. AGE (In years last birthday) 73		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) Cement Finisher-Ret			10b. KIND OF BUSINESS OR INDUSTRY Cement		11. BIRTHPLACE (City and State or Foreign Country) 4 Exeter, England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME William Hunt			13b. MOTHER'S MAIDEN NAME Lucy Conibear			14. NAME OF HUSBAND OR WIFE Elizabeth Wibbing Hunt		
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. 488-01-7563A		17. INFORMANT'S SIGNATURE OR NAME Florence Krause		ADDRESS 11 King-Lynn		
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) <i>Arterio insufficiency</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Syphilis (?)</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH years (?)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION .023 x				20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from Jan 8, 1957, to Jan 13, 1957, that I last saw the deceased alive on Jan 13, 1957, and that death occurred at 9:30 am., from the causes and on the date stated above.								
23a. SIGNATURE <i>Borke E. Mohr</i>				23b. ADDRESS 508 N. Grand		23c. DATE SIGNED Jan 15, 57		
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 1/15/57		24c. NAME OF CEMETERY OR CREMATORY Zions Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.		
DATE REC'D BY LOCAL REG. JAN 15 57		REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>		25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral		ADDRESS 1905 Union		

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Birckle Eck
508 No. Grand
Je 1-9501

Hrs. 9:30 - 11:30 AM

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 *Albert P. Thompson*.....

Licensed Embalmer No. *425*.....

P. O. Address *St. Louis*.....

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.