

FILED APR 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9757**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 91

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. CITY OR TOWN <u>St. Charles</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>0</u>		e. STREET ADDRESS (If rural, give location) <u>1609 Gallaher St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Joseph Ho spital</u>			
3. NAME OF DECEASED (Type or Print)	a. (First) <u>Helen</u>	b. (Middle) <u>Sadie</u>	c. (Last) <u>Hunn</u>
	4. DATE OF DEATH (Month) (Day) (Year) <u>March 19 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 22 1905</u>
9. AGE (In years last birthday) <u>51</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Miller, Neb.</u>
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13a. FATHER'S NAME <u>Fred Simshauser</u>		13b. MOTHER'S MAIDEN NAME <u>Lilian KNAPP</u>	14. NAME OF HUSBAND OR WIFE <u>Charles Hunn</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>507 01 2932</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Charles Hunn, St. Charles, Mo.</u>
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of the palate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7-11-49</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS	
ANTECEDENT CAUSES		DUE TO (b) _____	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		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? <u>2</u> 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) <u>144 x</u>	
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 <u>4-19-49</u> , 19 <u>  </u> , to <u>3-19-57</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>3-19-57</u> , 19 <u>  </u> , and that death occurred at <u>2P.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Paul H. Lotter M.D.</u>		23b. ADDRESS <u>114 N. Main St. St. Chas. Mo.</u>	23c. DATE SIGNED <u>3-20-57</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>March 22, 1957</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemet.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
DATE REC'D BY LOCAL REG. <u>Mar-21-57</u>	REGISTRAR'S SIGNATURE <u>Hazel Lawler</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur C. Paul St. Charles Mo.</u>	

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

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1951 12 004

**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 *Clarence M. Bulko*

Licensed Embalmer No. *4375*  
P. O. Address *2141 Chiles 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.