

FILED JUL 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25983

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6153

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY St. Louis

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) 1 day
c. CITY OR TOWN Dellwood 4000 d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 13 Incarnate Word Hosp. STREET ADDRESS (If rural, give location) 27 10193 Delridge Lane

3. NAME OF DECEASED (Type or Print) a. (First) JULIA b. (Middle) _____ c. (Last) BUGNITZ 4. DATE OF DEATH (Month) (Day) (Year) June 30, 1957

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH August 1, 1890 9. AGE (In years last birthday) 66 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 1 HR.: 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 Homemaker 11. BIRTHPLACE (City and State or Foreign Country) Austria 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Martin Taschler 13b. MOTHER'S MAIDEN NAME Agnes Shnatzler 14. NAME OF HUSBAND OR WIFE Leo Bugnitz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wa. or date of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Leo Bugnitz ADDRESS 10193 Delridge

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Metastatic Ca
* This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.
ANTERDENT CAUSES (b) Ca. of Nasal Sinus
* Forbid conditions of body giving rise to the above (a) stating the underlying condition last.
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) 160X

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 6/29, 1957, to 6/30, 1957, that I last saw the deceased alive on 6/30, 1957, and that death occurred at 2 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature] 23b. ADDRESS 2816 [Address] 23c. DATE SIGNED 7/1/57

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE July 3, 1957 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery 24d. LOCATION (City, town, or county) (State) St. Louis Mo.

DATE REC'D BY LOCAL REG. JH 2-57 REGISTRAR'S SIGNATURE [Signature] 25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS 267 Natural Bridge

WRITE PLAINLY—USING UNFADING 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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

James A. Lamm

Licensed Embalmer No. *41*

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.