

Health,
Welfare
Public
Service

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33302
STATE FILE NUMBER
8158
REGISTRAR'S NO.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY /	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Masonic Home		d. STREET ADDRESS 5351 Delmar	
Length of stay in 1b 4 Yrs.		(If outside, give location) 9/2	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last Doll y Catherine Bunsen			4. DATE OF DEATH Month Day Year 8- 31 1957				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9-1868		9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months 7 Days 22	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and state or country) New York N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mikel Joseph Hayes				14. MOTHER'S MAIDEN NAME Sarah Wiske			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No No			16. SOCIAL SECURITY NO. None		17. INFORMANT Masonic Home of Missouri, Linn C Robertson Secy.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION			INTERVAL BETWEEN ONSET AND DEATH ONE HOUR
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE ONE YEAR
			DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED ONE YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) HYPERTENSION 420.0			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE			

21. I attended the deceased from 8-20-1956 to 8-31-1957 and last saw her alive on 8-31-57
Death occurred at 8:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert A. Hall M.D.	22b. ADDRESS 5351 DELMAR ST. LOUIS, MO.	22c. DATE SIGNED AUG 31, 1957
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23a. BURIAL, CREMATION, REMOVAL (Specify) cremation	23b. DATE 9-3-1957	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR C. R. Lupton & Sons-7233 Delmar		25. DATE RECD. BY LOCAL REG. SEP 3 '57	26. REGISTRAR'S SIGNATURE J. Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 H. Murrain*

Licensed Embalmer No. *48*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.