

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42673

State File No. _____
Registrar's No. **11098**

FILED NOV 27 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE			b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (In this place)			c. CITY OR TOWN St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION 31 St. Louis State Hospital			e. STREET ADDRESS (If rural, give location) 2570 5944 Cabanne			d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or Print) Barbara Sunfield			a. (First)			b. (Middle)		
4. DATE OF DEATH (Month) (Day) (Year) November 18, 1957			5. SEX Female			6. COLOR OR RACE White		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED			8. DATE OF BIRTH November 22, 1912			9. AGE (In years last birthday) 44		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK			10b. KIND OF BUSINESS OR INDUSTRY AT HOME			11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		
12. CITIZEN OF WHAT COUNTRY? USA			13a. FATHER'S NAME John Karst			13b. MOTHER'S MAIDEN NAME Mary Kramer		
14. NAME OF HUSBAND OR WIFE John Sunfield			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 St. Louis State Hospital			ADDRESS 5400 Arsenal			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) Idiopathic encephalitis			INTERVAL BETWEEN ONSET AND DEATH 22 days			II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 343x		
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 7-2 , 19 51 , to 11-18 , 19 57 , that I last saw the deceased alive on 11-18 , 1957, and that death occurred at 6:20 p.m. , from the causes and on the date stated above.								
23a. SIGNATURE A. F. Heusler (Degree or title) M.D.			23b. ADDRESS 5400 Arsenal Street			23c. DATE SIGNED 11-19-57		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial			24b. DATE 11-21-57			24c. NAME OF CEMETERY OR CREMATORY MT OLIVE CEM.		
24d. LOCATION (City, town, or county) (State) LE MAY MO			25. FUNERAL DIRECTOR'S SIGNATURE Earl Willemann-Oberland, Mo			ADDRESS		
DATE REC'D BY LOCAL REG. NOV 20 57			REGISTRAR'S SIGNATURE J. Paul Smith, M.D.			25. FUNERAL DIRECTOR'S SIGNATURE Earl Willemann-Oberland, Mo		

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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 *Ernest Heleman*

Licensed Embalmer No. *3501*

P. O. Address *Orland 14 Va*

- 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.