

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038447

STATE FILE NUMBER

FILED OCT 20 1958

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2614

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY ST. LOUIS	
b. CITY OR TOWN RICHMOND HEIGHTS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN RICHMOND HEIGHTS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. MARYS Hosp		d. STREET ADDRESS 7315 GOFF Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILFRED Middle A Last HUNTER		4. DATE OF DEATH Month 10 Day 11 Year 58	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOK KEEPER		10b. KIND OF BUSINESS OR INDUSTRY SEAMAN-PRODUCTS	11. BIRTHPLACE (City and state or country) WELLSVILLE MO
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME ETHELBERT-HUNTER	
13b. MOTHER'S MAIDEN NAME HATTIE. V. HART		14. NAME OF HUSBAND OR WIFE GERTRUDE-HUNTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of dates of service) YES W.W.I		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address GERTRUDE-HUNTER- 7315 GOFF
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Artery Disease DUE TO (c) 4201A PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Tuberculosis			INTERVAL BETWEEN ONSET AND DEATH 3 da
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from Oct 7, 1958 to Oct 11, 1958 and last saw her alive on 10-10-58 Death occurred at 4:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W. Campbell (Degree or title) MD		22b. ADDRESS 4161 Leach Ave	
22c. DATE SIGNED 10/11/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-13-58	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL-PARK CEM.	23d. LOCATION (City, town, or country) (State) ST. LOUIS CO MO
24. FUNERAL DIRECTOR JAY B. SMITH ADDRESS MAPLEWOOD 17 MO.		25. DATE RECD. BY LOCAL REG. 10-12-58	26. REGISTRAR'S SIGNATURE Herbert N. Donke M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

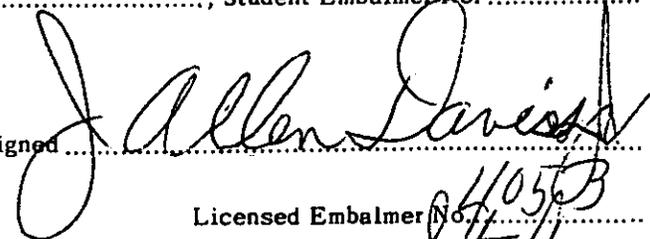
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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  _____
Licensed Embalmer No. 44057B _____
P. O. Address St. L. _____

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.