

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007730

STATE FILE NUMBER

2 1414

FILED FEB 24 1959 Registration District No. Primary Registration District No. Registrar's No.

300  
57  
93

|  |                        |   |  |
|--|------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis   |                        | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN St. Louis  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips  |                        | Length of stay in lb  | d. STREET ADDRESS (If outside, give location) 2503 Belleglade                                    |
| 3. NAME OF DECEASED First Middle Last<br>William S. Tunstall   |                        |   | 4. DATE OF DEATH<br>Month 2 Day 5 Year 59  |
| 5. SEX Male 2  | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 24, 1895   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Porter  |                        | 10b. KIND OF BUSINESS OR INDUSTRY none  | 9. AGE (In years last birthday) 63<br>IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min. |
| 11. BIRTHPLACE (City and state or country)<br>Byhalia, Miss.   |                        | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 13a. FATHER'S NAME Robert Fountain Tunstall  |                        | 13b. MOTHER'S MAIDEN NAME Texanna Watkins   | 14. NAME OF HUSBAND OR WIFE none   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>Yes Oct 2, 1919   |                        | 16. SOCIAL SECURITY NO. none  |  |
| 17. INFORMANT Robert VanBuren 3024 N. Euclid   |                        |   | Address  |
| 18. CAUSE OF DEATH (Enter only one cause positive for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pneumonia, lobar.   |                        |   | INTERVAL BETWEEN ONSET AND DEATH undet.  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) 490X<br>DUE TO (c)  |                        |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>Memia, Arteriosclerosis, Diabetes mellitus                        |                        |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <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<br>a.m.<br>p.m.  |                        |   |  |
| 20d. INJURY OCCURRED WHILE AT <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 1-27-59, to 2-5-59 and last saw him alive on 2-5-59<br>Death occurred at 3:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated. |                        |   |  |
| 22a. SIGNATURE J. A. Inasew (Degree or title), M.D.  |                        | 22b. ADDRESS 2601 N. Whittier St.   | 22c. DATE SIGNED 2-6-59  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   | 23b. DATE Feb 13, 1959 | 23c. NAME OF CEMETERY OR CREMATORY National Cemetery  | 23d. LOCATION (City, town, or county) (State) Jefferson Barracks Mo.                             |
| 24. FUNERAL DIRECTOR Price Funeral Home 2-29 Washington  |                        | 25. DATE RECD. BY LOCAL REG. FEB 10 59  | 26. REGISTRAR'S SIGNATURE Loan Smith, 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 *Edmund G. Flynn* .....

Licensed Embalmer No. 4444 .....

P. O. Address 4202 Finney Ave. .....

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.