

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030281

FILED VS AUG 1 8 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's **2-7277** STATE FILE NUMBER

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 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 | | Length of stay in 1b | c. CITY OR TOWN St. Louis |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 308 Clara Ave. |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|----------------------------------|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Lurline Middle Bunnell Last Bunnell | | | 4. DATE OF DEATH Month August Day 2 Year 1959 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1/7/1902 | 9. AGE (last birthday) 57 | IF UNDER 1 YEAR Months _____ Days _____ |
| | | | | | IF UNDER 24 HR 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 At Home | | 11. BIRTHPLACE (City and state or country) Alabama | 12. CITIZEN OF WHAT COUNTRY U.S. |
| 13a. FATHER'S NAME A. Ogletree | | 13b. MOTHER'S MAIDEN NAME Gertrude Matthews | | 14. NAME OF HUSBAND OR WIFE Paul | |

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| 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. Unknown | 17. INFORMANT Paul Bunnell, 308 Clara Ave. | Address |
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| 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 | | INTERVAL BETWEEN ONSET AND DEATH 6 mo |
| DUE TO (b) Advent coronary of sigmoid | | 8-9 mo |
| DUE TO (c) | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 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 _____ a.m. _____ p.m. Month, Day, Year _____ | 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 **May 59** to **Aug 1 1959** and last saw her alive on **Aug 1 1959**
Death occurred at **12:20 am Aug 2 1959** m on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|----------------------------|--|--|-----------------------------------|
| 22a. SIGNATURE (Degree or title) Joseph R. Sheahan | | 22b. ADDRESS 1617 Brentwood | | 22c. DATE SIGNED 8-4-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 8-5-59 | 23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. | |

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|--|--|--|--|
| 24. FUNERAL DIRECTOR Harrigan-Sheahan, 4700 Washington Blvd. | | 25. DATE RECD. BY LOCAL REG. AUG 5 '59 | 26. REGISTRAR'S SIGNATURE Paul Smith, M.D. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert M. Mur

Licensed Embalmer No. 3749

P. O. Address St. Louis

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