

FILED VS. APR 25 1960

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STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b <u>45 YRS.</u>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4717-ANDERSON-AV</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4717-ANDERSON-AV.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AUGUST</u> Middle <u>—</u> Last <u>HUNDELT</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>15</u> Year <u>1960</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-5-1895</u>	9. AGE (last birthday) <u>65 YRS.</u>		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) <u>MEAT-CUTTER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FLOWER-HILL-MARKET</u>		11. BIRTHPLACE (City and state or country) <u>ST. LIBORY-ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>HENRY-HUNDELT</u>			13b. MOTHER'S MAIDEN NAME <u>THERESA-BALMANN</u>			14. NAME OF HUSBAND OR WIFE <u>ALVINA-HUNDELT</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WORLD-WAR #1.</u>			16. SOCIAL SECURITY NO. <u>499-34-2198</u>		17. INFORMANT Address <u>ALVINA-HUNDELT-4717-ANDERSON-AV.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) _____			_____ <u>Cerebral thrombosis</u>				_____ <u>1 hour</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____ <u>Myocardial arteriosclerosis</u>					
			DUE TO (c) _____ <u>4201</u>					
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 type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u>Feb. 18, 1954</u> to <u>April 15, 1960</u> and last saw him alive on <u>April 14, 1960</u> Death occurred at _____ <u>3:15 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE _____ (Degree or title) <u>R.D.</u>				22b. ADDRESS <u>4703 Center Ave. St. Louis</u>			22c. DATE SIGNED <u>4-15-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4-18-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY-CEMETERY</u>		23d. LOCATION (City, town, or county) <u>ST. LOUIS - MO.</u>			(State)
24. FUNERAL DIRECTOR <u>Brockland Und. Co. 1827-HOGAN-ST.</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>APR 16 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(H.T.)

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 Calvin R. Padwa

Licensed Embalmer No. 4077

P. O. Address St Louis

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.