

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 18 1960

318

1003

4880

-60-020751

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b <b>LIFE</b>	c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DE-PAUL-HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1854-NO. MARKET - ST.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARCELLA - A. - BUNTE</b>			4. DATE OF DEATH Month Day Year <b>MAY - 6<sup>TH</sup> 1960</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-23-1910</b>	9. AGE (last birthday) <b>49 YRS.</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME-MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS - MO.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A</b>		13a. FATHER'S NAME <b>GEORGE - BUNTE</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA - RAPPS</b>	
14. NAME OF HUSBAND OR WIFE <b>( NEVER-MARRIED )</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO NONE</b>		16. SOCIAL SECURITY NO. <b>492-05-3333</b>	
17. INFORMANT ADDRESS <b>SYLVESTER-BUNTE: 1854 NO. MARKET - ST.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO (b) <b>Primary in breast.</b> DUE TO (c) <b>Metastatic carcinoma of the breast due to metastases</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>170X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <b>Collapsed on way to bathroom at</b>	
20c. TIME OF INJURY Hour s.m. p.m. <b>4-30-60</b>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., pick) <b>De Paul Hospital</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>St. Louis MO.</b>	
21. I attended the deceased from Death occurred at		21. I attended the deceased from <b>May 6</b> to <b>May 5</b> and last saw her alive on <b>May 5</b> Death occurred at <b>2:00 P.</b> m on the date stated above, end to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John A. Hastering, M.D.</b>		22b. ADDRESS <b>2801 N. Grand Blvd.</b>		22c. DATE SIGNED <b>5/9/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>MAY-10-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY-CEMETERY</b>	
23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Brockland Und.Co. 1827-HOGAN-ST.</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 9 1960</b>	
26. REGISTRAR'S SIGNATURE <b>Leon Smith, M.D.</b>					

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

*Plaine M. Bello*

Licensed Embalmer No. 4325

*St. Louis 23, Mo*  
P.O. Address \_\_\_\_\_

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