

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4268-61-015274 STATE FILE NUMBER

FILED MAY 10 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		a. STATE <u>Mo.</u>	b. COUNTY <u>St. Charles</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis City Hosp. # 1</u>		c. CITY OR TOWN <u>Rural - Portage Twnshp.</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>CHARLES</u>	Middle <u>P.</u>	Last <u>HUNN</u>	4. DATE OF DEATH	Month <u>May</u>	Day <u>3</u>	Year <u>1961</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-2-1897</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u>	IF UNDER 24 HR Hours <u>1</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired A.C.F.</u>	11. BIRTHPLACE (City and state or country) <u>West Alton, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Louis Hunn</u>	13b. MOTHER'S MAIDEN NAME <u>Irene Kuhn</u>	14. NAME OF HUSBAND OR WIFE <u>Helen Sinschhauser</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT <u>Hippolite Hunn</u>	Address <u>St. Charles, Missouri</u>
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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) <u>myocardial infarction</u>	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>coronary thrombosis</u> <u>4200</u>	
DUE TO (c) <u>arteriosclerotic heart disease</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Pulmonary infarction, anemia, hypertension</u>	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour <u>12:47</u> a.m. <u>p.m.</u> Month, Day, Year
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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 <u>Portage de Sioux, Missouri</u>	COUNTY	STATE
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21. I attended the deceased from <u>4/11/61</u> to <u>5/3/61</u> and last saw him <input checked="" type="checkbox"/> alive on <u>5/3/61</u> Death occurred at <u>12:47 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>David H. McHenry M.D.</u> (Degree or title)	22b. ADDRESS <u>1515 Lafayette Ave.</u>	22c. DATE SIGNED <u>5/3/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>5-6-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Portage de Sioux, Missouri</u>
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24. FUNERAL DIRECTOR <u>H.C. Dillman</u>	ADDRESS <u>St. Charles, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 5 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith M.D.</u>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

James R. Amalen

Licensed Embalmer No. *4832*

P. O. Address *St. Charles*

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.