

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026940
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6758

AMENDED **FILED JUL 26 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Length of stay in 1b	c. CITY OR TOWN <u>ST. LOUIS</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HAMILTON NURSING Home</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3131 OHIO</u>

3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>HUNZIKER</u> Last <u>HUNZIKER</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>18</u> Year <u>1961</u>				
5. SEX <u>FEMALE</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>NOV. 6 188V</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months: Days: Hours: Min.	IF UNDER 24 HR Hours: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIDOW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>		11. BIRTHPLACE (City and state or country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>NICHOLAS VOGEL</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>ARNOLD HUNZIKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>IDA PLUMMER 3131 OHIO</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>Basilar Artery Thrombosis</u>			<u>10 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Arteriosclerosis.</u>	<u>332x</u>	
	DUE TO (c)		

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 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.)
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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
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21. I attended the deceased from <u>10/13/60</u> to <u>7/18/61</u> and last saw him alive on <u>7/16/61</u> Death occurred at <u>2:30 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>Francis M. Cleef</u>	22b. ADDRESS <u>3720 Washington Ave</u>	22c. DATE SIGNED <u>7/19/61</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>JULY 21 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL CHURCHYARD</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>
25. DATE RECD. BY LOCAL REG. <u>JUL 20 1961</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr Morris Alue R.E. 3-6V2V
City Hosp. C.E. 1-3700

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 Corley T. Thompson Jr

Licensed Embalmer No. 4861

P. O. Address Slayer 5, Me

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.