

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036207

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9250** STATE FILE NUMBER

FILED SEP 28 1962

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Missouri | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Butler | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | c. CITY OR TOWN Quinlin | |
| Length of stay in lb | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HARVEY Middle B. Last GUNTER | | 4. DATE OF DEATH Month SEPTEMBER Day 25 Year 1962 | |
| 5. SEX Male | 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 10/19/1909 |
| 9. AGE (last birthday) 52 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 11. BIRTHPLACE (City and state or country) Bollinger Co., Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Hiram J. Gunter | | 13b. MOTHER'S MAIDEN NAME Ida V. Sitze | |
| 14. NAME OF HUSBAND OR WIFE Maude | | | |
| 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. Nil. | |
| 17. INFORMANT Bessie White, 4044 Shenandoah, Ave. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONALE DUE TO (b) PULMONARY BLASTOMYCOSIS DUE TO (c) 1340 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH 10 YEARS SEVERAL YRS. |
| 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 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 1340 | | COUNTY STATE |
| 21. I attended the deceased from SEPT. 16, 1962 to SEPT. 25, 1962 and last saw her/him alive on SEPT. 25, 1962 Death occurred at 5:28 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>C. P. Vanilla, M.D.</i> (Degree or title) M. D. | | 22b. ADDRESS BARNES HOSPITAL | |
| 22c. DATE SIGNED 9/25/62 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 9-25-62 | 23c. NAME OF CEMETERY OR CREMATORY Berger Cemetery | 23d. LOCATION (City, town, or county) (State) Oglesville, Mo. |
| 24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd. | | 25. DATE RECD. BY LOCAL REG. SEP 25 1962 | 26. REGISTRAR'S SIGNATURE <i>Coast Smith, M.D.</i> |

OCT 4 1962

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 *John J. Haines*

Licensed Embalmer No. 4108

P. O. Address *St. Michaels*

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.