

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044130

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11024**

STATE FILE NUMBER

FILED NOV 26 1962

VS 300  
Rev. 4/59

1

2 **20**

3

4 **1**

5 **2**

6

7 **0**

8 **2**

9

10

11

12 **90-0**

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Saint Louis (11)</b>              |  | a. STATE <b>Missouri</b>  | b. COUNTY   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>7529a Michigan Ave.</b> |  | c. CITY OR TOWN <b>Saint Louis (11)</b>   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| Length of stay in lb <b>45 Yrs.</b>   |  | d. STREET ADDRESS <b>7529a Michigan Ave.</b>  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|   |                                  |   |   |                                     |  |
|---|----------------------------------|---|---|-------------------------------------|--|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>EMMA E. L. DEGUNIA</b> |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Nov. 15 1962</b> |                                     |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/8/71</b>                        | 9. AGE (last birthday)<br><b>91</b> | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HR<br>Hours Min. |

|   |  |   |  |   |   |   |                        |
|---|--|---|--|---|---|---|------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>            |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b> |  | 11. BIRTHPLACE (City and state or country)<br><b>Washington Co. Mo.</b> |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                |                        |
| 13a. FATHER'S NAME<br><b>Jacob Boyer</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Rose Politte</b> |   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Robert Degunia (Dec.)</b> |                        |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>           |   | 17. INFORMANT<br><b>Cecelia Salls 7529a Michigan Ave.</b> |   | Address<br><b>(11)</b> |

|  |                                   |   |
|--|-----------------------------------|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |                                   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b> |
| IMMEDIATE CAUSE (a)  | <b>Cerebral thrombosis</b>        |   |
| Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.              | <b>Cerebral arterio-sclerosis</b> |   |
| DUE TO (b)   |                                   | <b>2 yrs</b>                                      |
| DUE TO (c)   |                                   | <b>332x</b>                                       |

|   |  |   |  |
|---|--|---|--|
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |
|---|--|---|--|

|   |   |  |              |
|---|---|--|--------------|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>a.m. p.m.   | 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 **Aug. 15-62** to **Nov. 15-62** and last saw her **live on Nov. 10-62**

Death occurred at **1:40 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

|  |  |                                     |
|--|--|-------------------------------------|
| 22a. SIGNATURE (Degree title)<br><b>George A. Sullivan, M.D.</b> | 22b. ADDRESS<br><b>7629 Quary ave.</b> | 22c. DATE SIGNED<br><b>11-16-62</b> |
|--|--|-------------------------------------|

|   |                                   |   |  |
|---|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>Nov. 17, 1962</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis (15) Mo.</b> |
|---|-----------------------------------|---|--|

|  |  |  |
|--|--|--|
| 24. FUNERAL DIRECTOR<br><b>Fendler Und. Co. 7420 Michigan Ave.</b> | 25. DATE REC'D BY REG.<br><b>NOV 16 1962</b> | 26. REGISTRAR'S SIGNATURE<br><b>Paul Smith, M.D.</b> |
|--|--|--|

USE BLACK INK  
OR  
TYPEWRITER RIBBON

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Geo. A. O' Sullivan  
7629 Irving Ave.  
PL 2-1242

FILED 6-13-68

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

*W. G. Peterson*

Licensed Embalmer No.

*3767*

P. O. Address

*7420 Michigan*

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.