

JAN 12 1940

791

Registration District No.

Primary Registration District No.

Registrar's No.

10820

1. PLACE OF DEATH:

(a) County 1000  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: De Paul Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution FEW hours.  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME ADOLPH D. BUNSEN

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Dollie Bunsen 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased August 6 1860  
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 11 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace not known Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Postal Inspector

11. Industry or business retired

MOTHER FATHER  
12. Name Charles O. Bunsen  
13. Birthplace not known Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Not known  
15. Birthplace not known Not known  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature AD Bunsen

(b) Address 5475 Cabanne Ave.

17. (a) Cremation (b) Date thereof 12-19-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Crematory

18. (a) Signature of funeral director A. H. K. Co

(b) Address 2707 North Grand Bl.

19. (a) DEC 19 1939 (b) J. J. Brubaker

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5475 Cabanne Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 17  
year 1939 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from 6-2, 1938, to 12-17, 1939, that I last saw him alive on Dec. 17, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Duration 3 yrs

Due to Arterio-sclerosis 3 yrs

Due to Nephritis, Chronic

Other conditions (Include pregnancy within 3 months of death)

Major findings: 131 PHYSICIAN \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_  
While at work? \_\_\_\_\_  
23. Signature Thos. M. Davis (M. D. or other) \_\_\_\_\_  
Address 2422 N. Grand Date signed 12/18/39

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed: *Paul H. Kwoleberg*

Licensed Embalmer No. *9631*

P. O. Address *2907 N. Grand*

**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 this body is not embalmed, above space should be left blank.**