

FILED SEP 17 1947 91
Registration District No. _____

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Enroute City Hospital 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **William Tune**
3. (b) If veteran, name war **No.**
3. (c) Social Security No. **Unk.**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **Widowed**
6. (b) Name of husband or wife **Edna** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 21 1902**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	39	5	4	_____ hr. _____ min.

9. Birthplace **Boulder Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Truck Driver**

MOTHER FATHER {
11. Industry or business _____
12. Name **John Tune**
13. Birthplace **Illinois**
(City, town, or county) (State or foreign country)
14. Maiden name **Kate John**
15. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mary O'Mara**
(b) Address **1338a Bayard Ave.**

17. (a) **Removal** (b) Date thereof **8/27/41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Keosport, Ill.**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Ave.**

19. (a) **AUG 26 1941** (b) **J. J. Bredbeck**
(Date of official registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1338a Bayard Ave.**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **25th**
year **1941** hour **4.** minute **57 P.M.**

21. I hereby certify that I attended the deceased from _____
_____ 19_____ to _____ 19_____
that I last saw him _____ alive on _____ 19_____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
**Cardiac Hypertrophy with failure;
Pulmonary Edema.**

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
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 **Thomas J. Callahan** (M.D. or other) _____
Address **Spring Carone** Date signed **8/26/41**

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 Guy W Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.