

FILED APR 24 1943

Registration District No. \_\_\_\_\_

Primary Registration District No. **5430**

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

1. PLACE OF DEATH:

(a) County **Franklin**

(b) City or town **Moselle**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**at Home**  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Franklin**

(c) City or town **Moselle**  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? **yes** (Yes or No)  
If yes, name country **Ireland**

3. (a) PRINT FULL NAME **Montrou de la Huntz**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **26th**  
year **1947** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex **male** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **Divorced**

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **NOT KNOWN**  
(Month) (Day) (Year)

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.

8. AGE: Years Months Days If less than one day

**Over 80** hr. \_\_\_\_\_ min.

Immediate cause of death **Cornary Thrombosis**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace **IRELAND CO. CLAIRE**  
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) **None**

10. Usual occupation **COREMAKER**

Major findings: Of operations **None**

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business **COMMONWEALTH STEEL**

12. Name **J. Thomas DeLa Huntz**

13. Birthplace **UNKNOWN**  
(City, town, or county) (State or foreign country)

14. Maiden name **ANN WATSON**

15. Birthplace **CORNWALL ENGLAND**  
(City, town, or county) (State or foreign country)

16. (a) Informant **CORNER**

(b) Address \_\_\_\_\_

17. (a) **Cremation** (b) Date thereof **4/3/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Louis, MO.**

18. (a) Signature of funeral director **Casey & Senox**

(b) Address **St. Clair, Springfield**

19. (a) **3-31-1947** (b) **E. H. Washington**  
(Date received local Registrar) (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence **F.O.A.D.**

(c) Where did injury occur? **Dead at home.**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature **E. H. Ottman** (b) **Coroner**  
Address **Union MO.** Date signed **3/28/47**

Date Filed 4-23-47

District File Number \_\_\_\_\_

District Health Officer No. 9,

RECEIVED

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 J. M. Lewis

Licensed Embalmer No. 3601

P. O. Address St. Clair, Mo.

**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, fact should be so stated above.