

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023170
STATE FILE NUMBER

FILED JUL 1 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6392

300
-57
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		Length of stay in lb 3 Wks 239	d. STREET ADDRESS (If outside, give location) 1721 Carroll St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) MARK BUNCH			4. DATE OF DEATH Month JUNE Day 24 Year 1958		
--	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1957	9. AGE (In years last birthday) 8	IF UNDER 1 YEAR Months 8 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
-----------------------	----------------------------------	---	--	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Infant)	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
---	--	---	--

13a. FATHER'S NAME Walter Bunch	13b. MOTHER'S MAIDEN NAME Ina Barton	14. NAME OF HUSBAND OR WIFE None
---	--	--

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. None	17. INFORMANT Walter Bunch, 1721 Carroll St.
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured - Bronchitis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) 5012		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) Bronchopneumonia		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 _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <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 5012	COUNTY	STATE
---	---	--	---	--------	-------

21. I attended the deceased from 6/4/58 , to 6/24/58 and last saw her alive on 6/24/58 Death occurred at 2:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) Dwight E. Carr M.D.	22b. ADDRESS 1515 LAFAYETTE	22c. DATE SIGNED JUN 24 '58
--	---------------------------------------	---------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-25-58	23c. NAME OF CEMETERY OR CREMATORY Bunch	23d. LOCATION (City, town, or country) (State) Bunker, Missouri
---	-----------------------------	--	---

24. FUNERAL DIRECTOR McLaughlin Funeral Home, Inc.	25. DATE RECD. BY LOCAL REG. JUN 24 '58	26. REGISTRAR'S SIGNATURE Charles Smith MO
--	---	--

27. ADDRESS 2301 Lafayette, St. Louis, Mo.		
--	--	--

(Print or Embelmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *James R. Chapman*
Licensed Embalmer No. *4550*
P. O. Address *St. Louis,*

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.