

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030220  
STATE FILE NUMBER

FILED AUG 28 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8135

5. 300  
1-57  
0

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Alexian Bros. Hosp.</b>			Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>2249 2738A Potomac St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>J.</b> Last <b>BUNK</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>21,</b> Year <b>1958</b>				
5. SEX <b>male</b> <input type="checkbox"/>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 21, 1894</b>		9. AGE (In years last birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe worker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Shipping</b>		11. BIRTHPLACE (City and state or country) <b>Scheller, Illinois /</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Frank Bunk</b>			13b. MOTHER'S MAIDEN NAME <b>Pauline Stanioch</b>			14. NAME OF HUSBAND OR WIFE <b>Gertrude Radake</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>yes 1st world war</b>			16. SOCIAL SECURITY NO. <b>492-01-6394</b>		17. INFORMANT <b>Gertrude Bunk</b> Address <b>3738 Potomac St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <b>Arterial hypertension</b>							<b>5 years</b>	
DUE TO (c) <b>331x</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							19. WAS AUTOPSY PERFORMED? 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 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		COUNTY		STATE
21. I attended the deceased from <b>Aug 11-58</b> to <b>8/21/58</b> and last saw <sup>her</sup> him alive on <b>Aug 30 1958</b> Death occurred at <b>12:00 am</b> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>B. J. McEnnis M.D.</b> (Degree or title)				22b. ADDRESS <b>16 Hampton Village Pl</b>			22c. DATE SIGNED <b>8-21-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Aug. 23-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Barbara Cath. Cemetery</b>		23d. LOCATION (City, town, or county) <b>Tamaroa, Illinois</b>		(State)	
24. FUNERAL DIRECTOR <b>Gebken Sons</b> ADDRESS <b>2630 Gravois Ave.</b>			25. DATE RECD. BY LOCAL REG. <b>AUG 21 1958</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, MD</b> S.P.			

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 *Herbert J. Lee Jr.* .....

Licensed Embalmer No. *4800* .....

P. O. Address *Hickman 22* .....

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.