

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038360

STATE FILE NUMBER

FILED OCT 17 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9673

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>01 227<sup>th</sup> PRESIDENT ST 324<sup>th</sup></u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>227<sup>th</sup> PRESIDENT</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD WUNSCH</u>			4. DATE OF DEATH Month Day Year <u>OCT 8 1958</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 7 1900</u>
9. AGE (In years last birthday) <u>58</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SET UP MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HAGER HINGE</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO 0</u>
12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>		13a. FATHER'S NAME <u>JOHN JACOB WUNSCH</u>	13b. MOTHER'S MAIDEN NAME <u>ANNA FRANK</u>
14. NAME OF HUSBAND OR WIFE <u>FRIEDA WUNSCH</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>494-09-2064</u>
17. INFORMANT Address <u>FRIEDA WUNSCH 227<sup>th</sup> PRESIDENT</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> DUE TO (b) _____ DUE TO (c) <u>Influenza</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriosclerosis</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>		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 <u>Jan 18, 1957</u> to <u>Oct 7, 1958</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>Oct 7 1958</u> Death occurred at <u>A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Leroy E Ellison</u> (Degree or title)		22b. ADDRESS <u>3610 So Broadway, St Louis</u>	22c. DATE SIGNED <u>10-9-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT 10 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW ST. MARCUS</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
24. FUNERAL DIRECTOR <u>Thomas Kutis 2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 9 '58</u>	26. REGISTRAR'S SIGNATURE <u>J Carl Smith MO</u> <u>MFB</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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1-4 Daily  
No. 6-416 P. 3

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 *Samuel C. Dill*

Licensed Embalmer No. *4347*

P. O. Address *2906 Dravni*

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.