

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022743

STATE FILING NUMBER
Registration No. 6065

FILED JUL 7 1959

Registration District No. Primary Registration District No.

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1910 Allen Ave.		d. STREET ADDRESS (If outside, give location) 1910 Allen	
3. NAME OF DECEASED (Type or print) First Middle Last Culus Constance Bunch		4. DATE OF DEATH Month Day Year June 26, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
11. BIRTHPLACE (City and state or country) Keenes, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Michael Croughan		13b. MOTHER'S MAIDEN NAME Martha Laughlin	14. NAME OF HUSBAND OR WIFE Robert E. Bunch
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No. Nil.		16. SOCIAL SECURITY NO. None	17. INFORMANT Address R. L. Plunkett, 1910 Allen, Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Essential hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331x			INTERVAL BETWEEN ONSET AND DEATH 3 yrs 6 yrs
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>Apr 10/56</u> to <u>June 26/59</u> and last saw her alive on <u>June 25/59</u> Death occurred at <u>7:45 a.m.</u> in on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) T. Schindewolf M.D.		22b. ADDRESS 2026 80th St	
22c. DATE SIGNED 6/26/59		22d. PLACE SIGNED (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-28-59	
23c. NAME OF CEMETERY OR CREMATORY Elmwood, Cemetery		23d. LOCATION (City, town, or county) Flora, Illinois.	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. JUN 26 '59	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 Elton R. Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.