

**MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-043103**

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3213 STATE FILE NUMBER

AMENDED

FILED NOV 21 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ill.</u> b. COUNTY <u>Madison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		Length of stay in lb <u>6 Days</u>	c. CITY OR TOWN <u>Granite City</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>Normandy Osteopathic Hos</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside give location) <u>2320 Lincoln Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Beth</u> Last <u>Bunker</u>			4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>61</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18-1905</u>	9. AGE (last birthday) <u>3</u>	IF UNDER 1 YEAR Months <u>3</u>	IF UNDER 24 HR Days <u>3</u> Hours <u>3</u> Min. <u>3</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>St Louis Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Orlie Bunker</u>	13b. MOTHER'S MAIDEN NAME <u>Ruth Reisinger</u>	14. NAME OF HUSBAND OR WIFE _____	

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>None</u>	17. INFORMANT <u>Ruth Bunker</u> Address <u>Granite City, Ill</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 days</u>
IMMEDIATE CAUSE (a) <u>Medullary Failure</u>	DUE TO (b) <u>Convulsions + Coma</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>Anesthesia</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>(d) Post operative hemorrhage following + A.</u>		PART III. If deceased was female was there a pregnancy in last 90 days. Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
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 WORK <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 _____
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21. I attended the deceased from 11-9-61 to 11-14-61 and last saw her alive on 11-14-61  
 Death occurred at 3:05 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Mary E. Richardson D.O.</u>		22b. ADDRESS <u>9553 Lackland Rd. St. Louis</u>		22c. DATE SIGNED <u>11-14-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-15-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Edwardsville Tenn. Ill</u>	
24. FUNERAL DIRECTOR <u>Peeper Funeral Home</u>	ADDRESS <u>Granite City, Ill</u>	25. DATE RECD. BY LOCAL REG. <u>11-14-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.