

OCT 12 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

31935
Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan 3 Registration District No. 85
 (b) Township 1 Primary Registration District No. 1001
 (c) City St. Joseph (d) Street No. St. Hospital #2 Registered No. 984
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred yrs. mos. 33 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Charles J. Bunker
 (a) Residence, No. State Hospital #2- St. Oregon, Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9 1868

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
71 9 2

8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. dry gds. merchant

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 24 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 21 1939, to Sept 24 1939
 I last saw him alive on Sept 11 1939. Death is said to have occurred on the date stated above, at 4 9 m.
 The principal cause of death and related causes of importance were as follows:

Gen. paralysis of the insane (syphilitic mening. encephalitic) Date of onset ?

Chronic myocarditis ?

Other contributory causes of importance: None

Name of operation None Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) T. J. Dell M. D.
 (Address) St. Joseph, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oregon, Mo.

13. NAME Wm. Bunker

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. 1

15. MAIDEN NAME Elizabeth Collins

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

17. INFORMANT Oliver H. Bunker, Oregon, Mo.
 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Oregon Mo. DATE Sept 26 1939

19. FUNERAL DIRECTOR (NAME) Pittsboro Funeral Service
 (ADDRESS) Oregon, Missouri

20. FILED 9-25-39 H. Westbush
 Local Registrar.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed James H. Pettigrew

Licensed Embalmer No. 3192

P. O. Address Oregon 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 this body is not embalmed, above space should be left blank.