

No. 2
-2-43
-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10903

FILED APR 7 1946
Registration District No. _____

Primary Registration District No. 3020

Registrar's No. 34

1. PLACE OF DEATH:
 (a) County Franklin.
 (b) City or town Washington.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Francis Hospital.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 days. (Specify whether years, months or days)
 In this community 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Franklin
 (c) City or town "Rural"
(If outside city or town limits, write "RURAL")
 (d) Street No. R. #1
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country X

3. (a) PRINT FULL NAME Neda Mary Laura Bunning.
 3. (b) If veteran, name war X
 3. (c) Social Security No. 493-01-0174

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband Roy F. Bunning
 6. (c) Age of husband 53 years if alive
 7. Birth date of deceased November 2nd, 1907
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>36</u>	<u>4</u>	<u>13</u>	hr. _____ min.

9. Birthplace Labadie, Missouri.
(City, town, or county) (State or foreign country)

10. Usual occupation Shoe-worker.

11. Industry or business X

MOTHER FATHER
 12. Name Hubert Duebbert.
 13. Birthplace Labadie, Missouri
(City, town, or county) (State or foreign country)
 14. Maiden name Emma Kenner
 15. Birthplace Boles, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Roy F. Bunning
 (b) Address Washington, Mo. R. #1

17. (a) Burial (b) Date thereof Mar. 18, 1944.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington, Mo.

18. (a) Signature of funeral director Wilburg & Vitt, Inc.

(b) Address Washington, Mo.

19. (a) 3/16/44 (b) Luella Ruether, Brook
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15th,
 year 1944 hour 8:00 minute 45 A.M.
 21. I hereby certify that I attended the deceased from Feb 29, 1944
 19 March 15, 1944
 that I last saw him alive on March 15, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia!
Pneumonia

Due to not known

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature J. P. Tom (M. D. or other)
 Address Washington, Mo. Date 3/16/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1151

AUG 17 1956

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-4-44

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 me

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

Signed [Signature]

Licensed Embalmer No. 2387

P. O. Address Washington, D.C.

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, fact should be so stated above.

Registration District No. 116

Primary Registration District No. 2020

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Washington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Neda M. L. Bunning

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race w

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 2 1913
(Month) (Day) (Year)

8. AGE: Years 26 Months 4 Days _____ If less than one day, _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15 year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Brain tumor
Diabetes

Due to Malignant tumor of the brain

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

10903