

No. 2  
8-13  
17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 4 1944  
Registration District No. 3076

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16017  
S State File No. 16017  
Registrar's No. 56

1. PLACE OF DEATH:  
(a) County Vernon  
(b) City or town Nevada Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 40 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Vernon  
(c) City or town Nevada  
(If outside city or town limits, write "RURAL")  
(d) Street No. 538 N Cedar  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Ellsworth Bunker  
(b) If veteran, name war no  
(c) Social Security No. no

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 18  
year 1944 hour 7 minute 10 M.  
21. I hereby certify that I attended the deceased from Dec 26/43  
to April 18 1944  
that I last saw him alive on April 18 1944  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W  
6. (a) Single, widowed, married, divorced Widowed  
(b) Name of husband or wife \_\_\_\_\_  
(c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death Acute Myocarditis  
Due to Influenza.  
Duration 3-m-

7. Birth date of deceased: July 24 1866  
(Month) (Day) (Year)  
8. AGE: Years 77 Months 9 Days 7  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions 93a  
(Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

MOTHER FATHER  
12. Name Samuel Bunker  
13. Birthplace Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Delia Bryant  
15. Birthplace Mo  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Gillie Bunker  
(b) Address Nevada Mo  
17. (a) Burial (b) Date thereof 4-20-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Deepwood Cem.  
18. (a) Signature of funeral director Henryson Hom  
(b) Address Nevada Mo  
19. (a) 4-27-44 (b) Hazel B. Burch  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_  
(Specify type of place)  
While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
23. Signature J. N. Love (M. D. or other) \_\_\_\_\_  
Address Nevada, Mo Date signed 4/25/44

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

1031

RECEIVED

District Health Officer No. 7,

District File Number 4-44-5-71

Date Filed 5-3-44

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 L B Terry

Licensed Embalmer No. 1960

P. O. Address Nevada M

**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.**