

No. 2  
2-45  
7-39  
X47070

**FILED SEP 16 1946**  
Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:  
 (a) County **Jackson**  
 (b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**General Hospital No. 1**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **14 days**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Jackson**  
 (c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **4911 E. 27**  
(If rural, give location)  
 (e) Citizen of foreign country? **no** (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Beverly Bunch**  
 3. (b) If veteran, name war **no**  
 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **Sept.** day **3**  
 year **1946** hour **3** minute **35 P.M.**  
 21. I hereby certify that I attended the deceased from  
**Aug. 20**, 19 **46** to **Sept. 3**, 19 **46**  
 that I last saw her **or** alive on **Sept. 3**, 19 **46**  
 and that death occurred on the date and hour stated above.

4. Sex **F** / race **white**  
 5. Color or race **white**  
 6. (a) Single, widowed, married, divorced **single**  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **Aug. 20, 1946**  
(Month) (Day) (Year)

Immediate cause of death **Prematurity**  
 Duration \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) **159**

8. AGE: Years \_\_\_\_\_ Months **14** Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_  
 9. Birthplace **Kansas City, Missouri**  
(City, town, or county) (State or foreign country)  
 10. Usual occupation **Infant**

PHYSICIAN  
 Underline the cause to which death should be charged statistically.  
 Major findings: **None**  
 Of operations \_\_\_\_\_  
 Of autopsy **None**

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
 12. Name **Mary Schirmer**  
 13. Birthplace **St. Joseph, Mo**  
(City, town, or county) (State or foreign country)  
 14. Maiden name **neal J. Bunch**  
 15. Birthplace **Richmond, Mo**  
(City, town, or county) (State or foreign country)  
 16. (a) Informant **John Cunningham**  
 (b) Address **4911 E 27**  
 17. (a) **Burial** (b) Date thereof **Sept 7-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **St. Louis Cemetery**  
 18. (a) Signature of funeral director **Theresa**  
 (b) Address **2512 Halton St**  
 19. (a) **9-4-46** (b) **Theraine Holmes**  
(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?  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury **1**  
 23. Signature **Wm W Hart** (M. D. or other) **MD**  
 Address **Med. Dir. Gen'l Hosp.** Date signed **9-4-46**

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

*A. M. M.*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed ~~by~~ *by*

..... Registered Apprentice No. ....

working under my personal supervision.

Signed

*Ph. Thissen*

Licensed Embalmer No. *2261*

P. O. Address *2512 Hillman St*

**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.**