

FILED MAR 11 1948

Registration District No. _____

Primary Registration District No. 5725

Registrar's No. 285

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

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Rural Hudson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Stell Hildreth Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. Nov 11-47 To Feb 29-48 Specify whether
In this community _____
years, months or days

3. (a) PRINT FULL NAME Edwin B Munsell

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife. Joe F Munseel 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased. June 6 - 1886
(Month) (Day) (Year)

8. AGE: Years 61 Months 8 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retail merchant

11. Industry or business _____

MOTHER FATHER

12. Name Frank Munseel

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

14. Maiden name Marion Hale

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

16. (a) Informant E. G Munseel

(b) Address Indianapolis Ind

17. (a) burial (b) Date thereof. 3/2/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shelbyville Ill

18. (a) Signature of funeral director Adolf Skun

(b) Address Macon

19. (a) 3/1/48 (b) Ruth Mcneely
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 29
year 1948 hour 4 minute 10 P. M.
21. I hereby certify that I attended the deceased from Nov 11-47 to Feb 29-48
that I last saw him alive on Feb 29 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 8 mo.

Due to _____

Due to _____

Other conditions Brachial neuritis
(Include pregnancy within 3 months of death)

Major findings: Of operations 93P
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 2

23. Signature W. Hoyle D.O. (M. D. or other)
Address Macon Mo Date signed 2/29/48

RECEIVED
District Health Officer No. 10
District File Number 348479
Date Filed MAR 10 1948

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.....

Thos. L. Bell....., Registered Apprentice No. *37*
working under my personal supervision.

Signed *Albert Skinner*.....

Licensed Embalmer No. *75-1*.....

P. O. Address *Macon 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, fact should be so stated above.