FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 13 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25721

Registration District No. 39 — Primary Registration District No. 5227 — Registrar's No. 155

1. PLACE OF DEATH:
(a) County: Cass
(b) City or town: Rural Pecular Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

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")
(d) Street No.: 4739 Wyoming St 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: RAYMOND KENNETH NUNNS
3. (b) If veteran, name war: WORLD WAR II
3. (c) Social Security No.: 495-20-8096
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Jan (Month) 21 (Day) 1928 (Year)

8. AGE: Years 20 | Months 7 | Days 14 | If less than one day ..... hr ..... min.

9. Birthplace: Kansas City (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Press Feeder
11. Industry or business: Bemis Bag Co
MOTHER FATHER
12. Name: C. H. Nunns
13. Birthplace: Lamar (City, town, or county) Mo (State or foreign country)
14. Maiden name: Inez Potter
15. Birthplace: Kentanee (City, town, or county) Ill. (State or foreign country)
16. (a) Informant: C. F. NUNNS
(b) Address: 4739 Wyoming St K.C. Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date: Sept 7-1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Lamar Mo.
18. (a) Signature of funeral director: Romaine Funeral Home
(b) Address: Lamar Mo.
19. Sept. 5-1948 (Date received local registrar) (b) Laura J. Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5 year 1948 hour 12:15 minute A M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h..... alive on ..... 19.....; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: FRACTURE SKULL
COMPOUND FRACTURE L. TIBIA
& FIBULA
Due to: AUTO ACCIDENT
Due to: .....
Other conditions (Include pregnancy within 3 months of death): .....
Major findings: Of operations: .....
Of autopsy: .....

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): Accident
(b) Date of occurrence: Sept 5 1948 14
(c) Where did injury occur? Harrisonville Cass Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway #71 (Specify type of place)
While at work? No (e) Means of injury .....
23. Signature: O. J. Barger (M.D. or other) MD
Address: Harrisonville Mo Date signed: 9/5/48
Coroner — Cass Co.

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 17 1948

SEP 27 1948

SEP 29 1960

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 Ernest Kunnenburger

Licensed Embalmer No. 3368

P. O. Address Harrisonville 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.