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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25765**

FILED SEP 3 1948
Registration District No. **71**

Primary Registration District No. **3012**

Registrar's No. **109**

1. PLACE OF DEATH:

(a) County **Clay**

(b) City or town **Excelsior Springs Mo**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
542 Kansas City Ave /
(If not in hospital or institution, write street number or location)

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

In this community **16 Years**
years, months or days)

3: (a) PRINT FULL NAME **NATHAN E. MUNDON**

3. (b) If veteran, **No** name war

3. (c) Social Security No. **No**

4. Sex **Male**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Florence E. Mundon**

6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **Nov 28 1889**
(Month) (Day) (Year)

8. AGE: Years **88** Months **8** Days **20**
If less than one day hr. min.

9. Birthplace **##### Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business

12. Name **Unknown** 9

13. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown** 9

15. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Florence Mundon**

(b) Address **542 K.C. Ave - Ex. Springs Mo**

17. (a) **Burial** (b) Date thereof **8-19-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bourmoir Ia**

18. (a) Signature of funeral director **C. Hall V. Hope**

(b) Address **Excelsior Springs Mo**

19. (a) **8/19/48** (b) **Caroline Hutchings**
(Date to received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Clay** 24

(c) City or town **Excelsior Springs**
(If outside city or town limits, write "RURAL")

(d) Street No. **542 Kansas City Ave**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **18**
year **1948** hour **9** minute **05 A.M.**

21. I hereby certify that I attended the deceased from **June** 19**48** to **Aug 18** 19**48**
that I last saw him alive on **Aug 18** 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**

Due to **lung injury & fall**
& fractured ribs

Other conditions **Cu of Lung**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **18**

Of autopsy **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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) **18**

(b) Date of occurrence **24**

(c) Where did injury occur? **24**
(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 **C. Hall V. Hope** (M. D. or other) **M.D.**

Address **Excelsior Springs Mo** Date signed **8/19/48**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,
District File Number _____

Date Filed 9-2-48

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 James A. Moles
Licensed Embalmer No. 3296

P. O. Address Ex. Spring 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.

Registration District No. 71

Primary Registration District No. 3012

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs
(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

Nathan E. Munden

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

4. Sex m 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 Mr. 28
(Month) (Day) (Year)

8. AGE: Years 88 Months 8 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (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 Aug Day 8
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

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) accident - fall

(b) Date of occurrence accidental - not definitely

(c) Where did injury occur? Excelsior Springs Mo. 24
(City or town) (County) (State)

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

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

23. Signature G. P. Robinson (M. D. or other) _____

Address Excelsior Springs, Mo Date signed 9/11/48

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

SUPPLEMENTARY

5-25765 1948