

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7262**

FILED MAR 30 1949

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

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>9000</u>		Registrar's No. <u>84</u>			
1. PLACE OF DEATH a. COUNTY <u>ADAIR</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SULLIVAN/US</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KIRKSVILLE</u>		c. LENGTH OF STAY (In this place) <u>11 MONTHS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WINIGAN</u>		0			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>COMMUNITY NURSING HOME #1</u>				d. STREET ADDRESS (If rural, give location) <u>NO ST. ADDRESS</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>FLORA</u> b. (Middle) <u>BELL</u> c. (Last) <u>MUNNS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 18 1949</u>						
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JUNE 22, 1878</u>		9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>KNOX Co., MO.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>WILLIAM P. LINVILLE</u>			13b. MOTHER'S MAIDEN NAME <u>ROSA JANE Mc WILLIAM</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN MUNNS</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>George Munns, Winigan, Mo.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebratory collapse</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Uremia poisoning</u> DUE TO (c) <u>Chronic glomerulonephritis</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>8 mos.</u> <u>Year</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>592X</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Sept 8, 1948</u> , to <u>Mar 18, 1949</u> , that I last saw the deceased alive on <u>March 18, 1949</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>M.T. Lutensohn D.O.</u>				23b. ADDRESS <u>Kirkville, Mo</u>			23c. DATE SIGNED <u>3-18-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MARCH 20, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>PRICE CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>SONN Co. MO</u>				
DATE REC'D BY LOCAL REG. <u>Mar 18-49</u>		REGISTRAR'S SIGNATURE <u>Hate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Glenn E. Ford & Son, Sun City, Mo.</u>					

RECEIVED

District Health Officer No. 10

District File Number 3-49-55

Date Filed MAR 29 1949

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 _____

Karl R. Kent

Student Embalmer No. 243

working under my personal supervision.

Signed Karl R. Kent
Student Embalmer

Signed Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Shrewsbury, 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.