

FILED APR 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12312
State File No. 1546

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE <u>MO</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City, Mo.</u> c. LENGTH OF STAY (In this place) <u>2 wks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Harrisonville</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>908 Charlotte</u>		d. STREET ADDRESS (If rural, give location) <u>Locust Lodge</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Charles Fredrick Bunger</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 6-1949</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 9-1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (State or foreign country) <u>Napoleon O Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Geo. H Bunger</u>	
13b. MOTHER'S MAIDEN NAME <u>Jane F Miller</u>		14. NAME OF HUSBAND OR WIFE <u>Una (Bullock) Bunger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Waxne Bunger</u> ADDRESS <u>908 Charlotte E. 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>Chronic Valvular Heart Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>alcoholism</u> DUE TO (b) <u>---</u> DUE TO (c) <u>---</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>3222</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) (Min)		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>4/1</u> , 19 <u>49</u> , to <u>4/6</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>4/6</u> , 19 <u>49</u> , and that death occurred at <u>11 P. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>R. A. Williams</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>5400 St. John Ave. Mo.</u>	
23c. DATE SIGNED <u>4-7-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Apr. 9-49</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Garden City</u>		24d. LOCATION (City, town, or county) (State) <u>Garden City Mo.</u>	
DATE REC'D BY LOCAL REG. <u>4-7-49</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>	
25. GENERAL DIRECTOR'S SIGNATURE <u>William D. ...</u>		ADDRESS <u>Harrisonville Mo</u>	

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

NOV 10 1970

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~~ _____

Student Embalmer No. _____

working under my personal supervision.

Signed Floyd Ottinson

Signed _____
Student Embalmer

Licensed Embalmer No. 3970

P. O. Address Harrisville

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.