

FILED SEP 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30156

0400
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BIRTH NO. _____ REG. DIST. NO. ¹³² ~~137~~ PRIMARY REG. DIST. NO. ⁵⁴⁷ ~~202~~ Registrar's No. ¹⁰⁵

1. PLACE OF DEATH a. COUNTY <u>Grundy</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Grundy</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Galt</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Galt</u>	
c. LENGTH OF STAY (in this place) <u>Life</u>		d. STREET ADDRESS (If rural, give location) <u>Rural Liberty Twp</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED (Type or Print) a. (First) <u>BESSIE LEE TUNNELL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8-5-50</u>	
b. (Middle)		c. (Last)	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 3 1884</u>
9. AGE (In years last birthday) <u>65</u>		10. CITIZEN OF WHAT COUNTRY <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>No occupation</u>		11. BIRTHPLACE (State or foreign country) <u>Sullivan Co Mo</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>John Tunnell</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah King</u>	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Bessie Tunnell</u>		ADDRESS <u>Galt Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis Chronic</u>		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			
II. OTHER SIGNIFICANT CONDITIONS		4222	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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>1-1-50</u> , 19 <u>50</u> , to <u>8-5-50</u> , that I last saw the deceased alive on <u>8-4-</u> , 19 <u>50</u> , and that death occurred at <u>1:12 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>D. C. Weston, M.D.</u> (Degree or title)		23b. ADDRESS <u>Galt, Mo</u>	
23c. DATE SIGNED <u>8-6-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>1. Burial</u>		24b. DATE <u>8-7-50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Galt mo</u>		24d. LOCATION (City, town, or county) (State) <u>Galt mo</u>	
DATE REC'D BY LOCAL REG. <u>8/9/50</u>		REGISTRAR'S SIGNATURE <u>Jane Saw</u> ¹¹⁵	
25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Payne</u>		ADDRESS <u>Wm Galt mo</u>	

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



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.

Student
Student Embalmer

Signed R. K. Payne Jr.

Licensed Embalmer No. 3400

P. O. Address Salt

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.