

FILED OCT 4 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29880

State File No.

BIRTH NO. 59233-54 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1031

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before adjustment). a. STATE <u>Kansas</u> b. COUNTY <u>Danforth</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph,</u>	c. LENGTH OF STAY (in this place) <u>1 day</u>	c. CITY OR TOWN <u>Elwood</u>	d. Is Residence within limits of a city incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		STREET ADDRESS (If rural, give location) <u>None</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Sherry</u> b. (Middle) <u>Lynn</u> c. (Last) <u>Munger</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 15 1954</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 14/1954</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Joseph, Mo</u>	
13a. FATHER'S NAME <u>Raymond Munger</u>			13b. MOTHER'S MAIDEN NAME <u>Juanita Corcoran</u>		14. NAME OF HUSBAND OR WIFE <u>none</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>Raymond Munger Elwood, Kansas</u>	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Anem. cephalic thromb.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u>
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>750 X</u>			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) (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 Sept 14, 1954, to Sept 15, 19 54 that I last saw the deceased alive on Sept 15, 1954, and that death occurred at 10:A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Arthur Allison MD</u>		23b. ADDRESS <u>Tootle Bldg, St/ Joseph Mo</u>		23c. DATE SIGNED <u>9/16/54</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>9/16/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas</u>	
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DATE REC'D BY LOCAL REG. <u>Sept. 28, 1954</u>		REGISTRAR'S SIGNATURE <u>Arthur M. Allison</u> 485		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John Rupp St. Joseph, Mo</u>	
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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, ~~_____~~ *Baker* was not embalmed, Student Embalmer No. _____ working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed *Allan C. Rayan*

Licensed Embalmer No. *479*

P. O. Address *St. Joseph*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.