. Health, & Welfare
. Public
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-024592
STATE FILE NUMBER

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 109

1. PLACE OF DEATH
a. COUNTY Cooper
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Boonville — Inside Limits Yes XX No
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Joseph Hosp — Length of stay in 1b 9 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Howard
c. CITY OR TOWN Boonslick Township — Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) Rt. 1 Franklin — Reside on Farm Yes XX No

3. NAME OF DECEASED (Type or print) First Walter Middle K. Last MUNDAY
4. DATE OF DEATH Month Aug. Day 3, Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH March 18, 1873
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, Retired
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (City and state or country) Howard County, Mo.
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Larkin L. Munday
13b. MOTHER'S MAIDEN NAME Luvinia Aimsworth
14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 495-40-4529
17. INFORMANT Address Miss Maude Munday, Franklin, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Unknown
DUE TO (c) 4301.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) x
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year x
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) x
20f. CITY, TOWN, OR LOCATION x COUNTY STATE

21. I attended the deceased from July 25, 1959, to Aug. 3, 1959 and last saw her/him alive on Aug. 3, 1959
Death occurred at 5:15 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) L. L. Chamberlain M.D.
22b. ADDRESS Boonville, Mo
22c. DATE SIGNED 8/3/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 8-5-1959
23c. NAME OF CEMETERY OR CREMATORY Boonesboro Cemetery
23d. LOCATION (City, town, or county) (State) Boonesboro, Howard Co.Mo.

24. FUNERAL DIRECTOR ADDRESS Markland - Hall New Franklin, Mo.
25. DATE REC'D BY LOCAL REG. 8/4/59
26. REGISTRAR'S SIGNATURE B. E. Hooper
(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

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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 .....
Signature of Student Embalmer

Signed Tom D. Markland

Licensed Embalmer No. 4592

P. O. Address New Franklin

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.