

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-005105

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 1 Primary Registration District No. 4024 Registrar's No. 14

STATE FILE NUMBER

FILED MAR 13 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY BARRY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY BARRY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CASSVILLE		c. CITY OR TOWN CASSVILLE	
Length of stay in 1b 20 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 205 E. 7th.		d. STREET ADDRESS (If outside, give location) 205 E. 7th.	
3. NAME OF DECEASED (Type or print) First ALBERT Middle LEROY Last MUNDAY		4. DATE OF DEATH Month March Day 7 Year 1963	
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/2/1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Barry Co., Mo.
13a. FATHER'S NAME C.H. Munday		13b. MOTHER'S MAIDEN NAME Sarah Beek	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) no		17. INFORMANT Sam Munday, Cassville, Mo.	
18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decomposition Influenza Interval between onset and death 3 yrs 1 week.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour, a.m. or p.m. Month, Day, Year.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from March 1959 to March 1963 and last saw him alive on Feb 28-1963 Death occurred at 12:00 p. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Dapurus D.O.		22b. ADDRESS Cassville, Mo	
22c. DATE SIGNED 3-8-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/9/63	
23c. NAME OF CEMETERY OR CREMATORY Mineral Springs Cem.		23d. LOCATION (City, town, or county) Barry Co., Mo.	
24. FUNERAL DIRECTOR D.E. Williamson, Cassville, Mo.		25. DATE RECD. BY LOCAL REG. Mar 9-63	
		26. REGISTRAR'S SIGNATURE Grace Williams	

USE BLACK INK OR TYPEWRITER RIBBON

MAR 18 1963

Burial permit obtained Mar 9-63
S.W.

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 Dyle E. Williams

Licensed Embalmer No. 4883

P. O. Address Cassville 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
• If this body is not embalmed, fact should be so stated above.