

FILED SEP 8 1944

Registration District No. 77

Primary Registration District No. 3012

State File No. _____

Registrar's No. 117

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 months, 26 days
In this community 11 months, 26 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Alfred F. Munson

3. (b) If veteran, name war World War I 3. (c) Social Security No. Yes, not remembered

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Jocie Munson 6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased May 12, 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>3</u>	<u>9</u>	hr. min.

9. Birthplace Assaria, Kansas (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Farming

12. Name John Munson

13. Birthplace Sweden (City, town, or county) (State or foreign country)

14. Maiden name Matilda Landon

15. Birthplace Sweden (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records, Veterans Administration
(b) Address Excelsior Springs, Mo.

17. (a) Removal (b) Date thereof 8-21-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: Berryville, Arkansas

18. (a) Signature of funeral director Herbert Hope
(b) Address Excelsior Springs, Missouri

19. (a) 8-21-44 Mrs. Sadie Redman (Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Carroll
(c) City or town Grandview
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21 year 1944 hour 2:15 minute A. M.

21. I hereby certify that I attended the deceased from August 26, 1943, to August 21, 1944
that I last saw him alive on August 21, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, chronic far advanced, active Duration unknown

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy As shown above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: / _____

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) _____
Means of injury _____

23. Signature Ernest M. Tapp (M. D. or other) MD
Address Veterans Administration Date signed 8-21-44

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

9-7-44

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 _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Chas Vingel Hope

Licensed Embalmer No. 3950

P. O. Address _____

Excelsior Springs

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.