MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Pettis

Township _____ or Village _____ or City Sedalia (NO. 403 E Bwd. St.; _____ Ward)

Registration District No. 668 File No. 22194

Primary Registration District No. 3032 Registered No. 181

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Charles DeForest Gunder

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE / MARRIED / WIDOWED / OR DIVORCED (Write the word)
M	W	S

DATE OF BIRTH June (Month) 11 (Day), 1916 (Year)

AGE — yrs. — mos. 14 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Sedalia Mo

PARENTS
NAME OF FATHER S. E. Gunder
BIRTHPLACE OF FATHER (City or town, State or foreign country) Iowa
MAIDEN NAME OF MOTHER Kate McCormick
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. E. Gunder

(ADDRESS) Sedalia Mo

Filed June 26 1916 R. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June (Month) 25 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from June 11, 1916, to June 23, 1916, that I last saw him alive on June 23, 1916, and that death occurred, on the date stated above, at Dont know m.

The CAUSE OF DEATH* was as follows:

Imperforate Anus.

157D Operation.

(Duration) _____ yrs. 15 mos. 14 ds.

Contributory (SECONDARY) Infection

(Duration) _____ yrs. _____ mos. 5 ds.

(Signed) Edw. A. Albers M. D.

June 26, 1916 (Address) Sedalia Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Sedalia Mo

DATE OF BURIAL June 26 1916

UNDERTAKER McLaughlin

ADDRESS Sedalia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

occupation is very important, so that the relative ... pneumonia ("Pneumonia," unqualified, is ... Tuberculosis of lungs, meninges, peritoneum, etc.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... or Village ..... or City ..... (NO. ....., ... St.; ..... Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h.....alive on ....., 191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
UNDERTAKER	ADDRESS