

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

Do not use this space.

1929

1. PLACE OF DEATH

40189

County Greene Registration District No. 318 File No. 846
 Township Springfield Primary Registration District No. 2001 Registered No. 846
 City Springfield (No. Baptist Hospital) St. _____ Ward _____

2. FULL NAME

Bryan Mundy

(a) Residence. No. Marshallfield Mo. St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Virginia Mundy

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 1 - 1897

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
31 4 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mail (rural)
 (b) General nature of industry, business, or establishment in which employed (or employer) carrier
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Vernon Co. Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER R. L. Mundy

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Lizzie Carr

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)

14. INFORMANT R. L. Mundy
 (Address) R.C. Mo.

15. FILED 175 28 Cl. Forest Mo.
 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-4-28

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ 8 P. M.

18. THE CAUSE OF DEATH WAS AS FOLLOWS:
Multiple injuries, Fracture of skull, Hemorrhage of RR, crossing accident, Time 3 hours (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Accident in Webster Co
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? Yes DATE OF Dec 4, 1928
 WAS THERE AN AUTOPSY? No

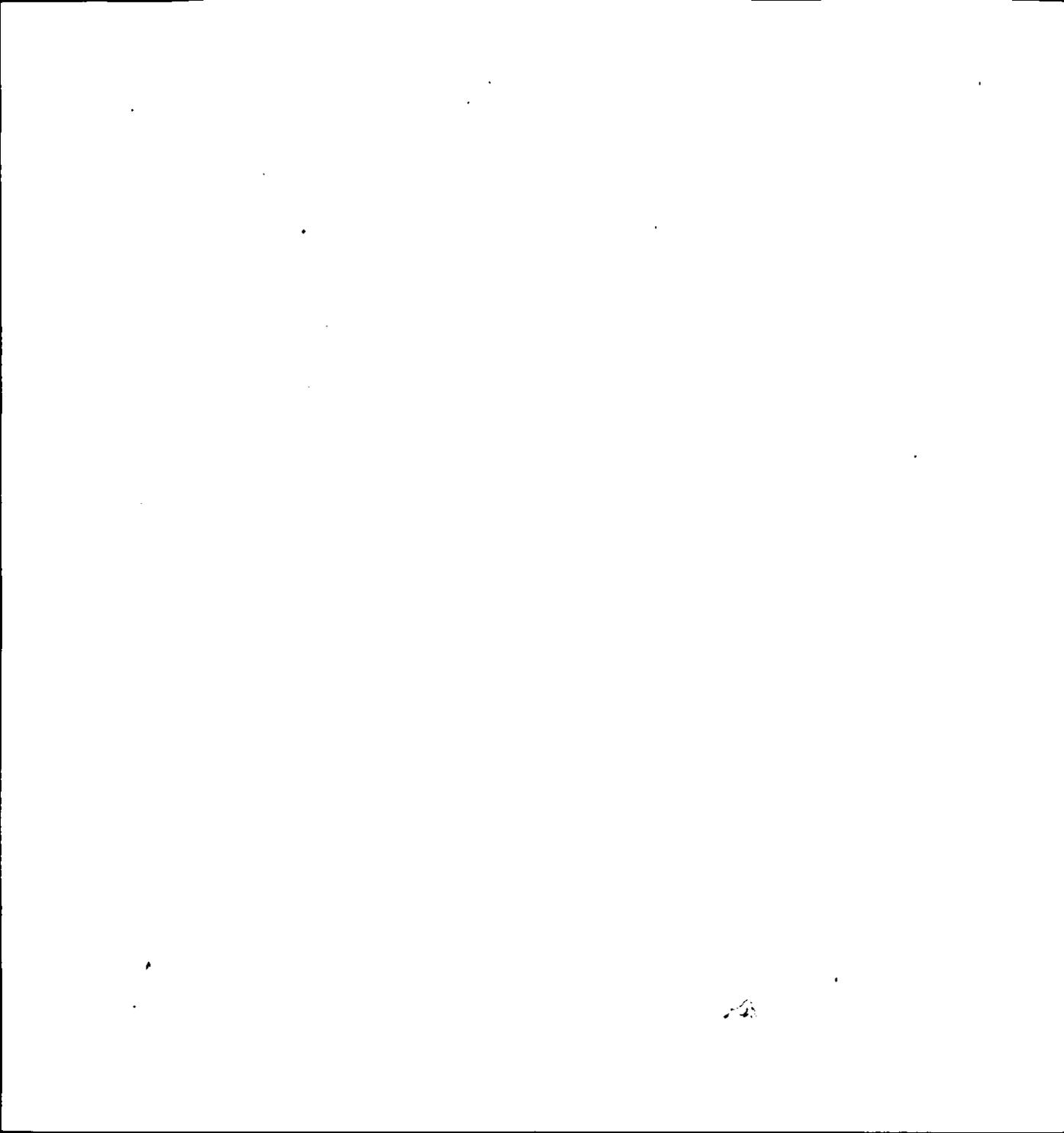
WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Monica Coste, Crayer M. D.
 _____, 19____ (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Marshallfield Mo. DATE OF BURIAL 12-6-28

20. UNDERTAKER Alma Schreyer ADDRESS 534 St. Louis

PARENTS



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. _____
 Township _____ Primary Registration District No. 2001 Registered No. 846
 City Springfield St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY)

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

14. INFORMANT (Address) _____

15. FILED 12/6 29 Oct 1929 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 4 - 19 28

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____, alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

*Multiple injuries
fracture of skull - Hemorrhage
Crossing accident
H. H. Webster Co. (duration) yrs. mos. ds.
Mobile in accident*

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
 _____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-40189