

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

Do not use this space.

1775

1. PLACE OF DEATH

County Jackson
Township Haw
City Kansas City

Registration District No. 399

Primary Registration District No. 1002

File No. _____
Registered No. 357
St. _____ Ward _____

2. FULL NAME

Charles Thomas Bunch

(a) Residence. No. 1407 Harrison St., _____ Ward _____

(Usual place of abode) res. in block

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 12 - 1910

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. or ____ min.
10 5 12

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Pupil 4th Grade
(b) General nature of industry, business, or establishment in which employed (or employer) Hamilton School
16th - Campbell
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Andrew County
(STATE OR COUNTRY) Amazonia Mo.

10. NAME OF FATHER Charles Bunch

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

12. MAIDEN NAME OF MOTHER Dora Adella Adams

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

14. INFORMANT Mrs. Char Bunch
(Address) 1407 Harrison

15. FILED 12529 M. M. Crow
REGISTRAR Asst

20 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 28 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS
Accidental fracture of skull - fell from pole

CONTRIBUTORY (SECONDARY) 180A
1913 (duration) _____ yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) Ed. C. ... M. D.

*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 Forest Hill DATE OF BURIAL Jan. 28 1929

20. UNDERTAKER Eylan Funeral Home ADDRESS 1800 Linwood Blvd.

INK--THIS IS A PERMANENT RECORD. Every item carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language that it may be properly classified. Exact statement of OCCUPATION is very important.

26-1-1-2

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 399 File No.
Township..... Primary Registration District No. 1002 Registered No. 367
City H. City (No.) St. Ward)

2. FULL NAME

Charles Thomas Bunch

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

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 W (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 12, 1918

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>10</u>	<u>5</u>	<u>12</u>		

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 1/25, 19 29 M M Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 24 19 29

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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

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

SUPPLEMENTARY

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