

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

8604

1. PLACE OF DEATH

111 County *Wayne*
2 Township *Redmont*
City *Redmont* (No. *1*)

Registration District No. *891*
Primary Registration District No. *4540*

File No. _____
Registered No. *17*
St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred *12* yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female*
4. COLOR OF RACE *white*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2/4* 19*31*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Fred Edward Bumpard*

17. I HEREBY CERTIFY, That I attended deceased from *2/1/31* to *2/4/31* and that I last saw *her* alive on *2/4/31*, 19*31*, and that death occurred, on the date stated above, at *5:45 a. m.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 31 1879*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
49 0 4

Tuberculo-pneumonia
107A

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer) *235*
(c) Name of employer _____

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) *none* (duration) _____ yrs. _____ mos. _____ ds.

9. BIRTHPLACE (CITY OR TOWN) *Patterson MO*
(STATE OR COUNTRY) _____

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, _____ (1)

10. NAME OF FATHER *Frank Clark*

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

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

20. WAS THERE AN AUTOPSY? *no*

12. MAIDEN NAME OF MOTHER *Mary James*

WHAT TEST CONFIRMED DIAGNOSIS *stethoscope*

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

(Signed) *H. W. Jones* M. D.

14. INFORMANT *Blanche White Birch*
(Address) *Redmont*

, 19 _____ (Address) *Redmont*

15. FILED *2/24/31* *G. O. Piles M.D.* REGISTRAR

*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 *Starks Cem* DATE OF BURIAL *2/5 1931*

20. UNDERTAKER *Dish and co.* ADDRESS *Redmont*

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

APR 27 1931

51-6-3

**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 Wayne Registration District No. 891 File No.
 Township Primary Registration District No. 4340 Registered No. 7
 City Diedmont (No.) St. Ward)

2. FULL NAME Grace Idell Bunyard

(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 F 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) July 31-1879

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
57 4 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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 570 31 9 10 Idell M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-4 19 31

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

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

19

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

SUPPLEMENTARY

5-8604