

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

Do not use this space.

JUN 4 1935

18672

1. PLACE OF DEATH

County Lea Registration District No. 820
 Township Jefferson Primary Registration District No. 4496
 City Oran (No. _____) St. _____ Ward _____

2. FULL NAME

Emanuel Muncie
 (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Hendricka Muncie WIFE OF _____

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
63 3 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming
 (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) Boon Co. Mo.

10. NAME OF FATHER David Muncie

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

12. MAIDEN NAME OF MOTHER Chickasha

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

14. INFORMANT Mary Muncie

(Address) _____

15. FILED 5/9, 1935 J. Wickman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/4 1935

17. I HEREBY CERTIFY, That I attended deceased from now, 1935, to 5/4, 1935 that I last saw him alive on 3/26, 1935, and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Diarrhoea

CONTRIBUTORY (SECONDARY) Fractured hip (duration) 1 yrs. _____ mos. _____ ds.

(duration) 6 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) J. A. Clark, M. D.

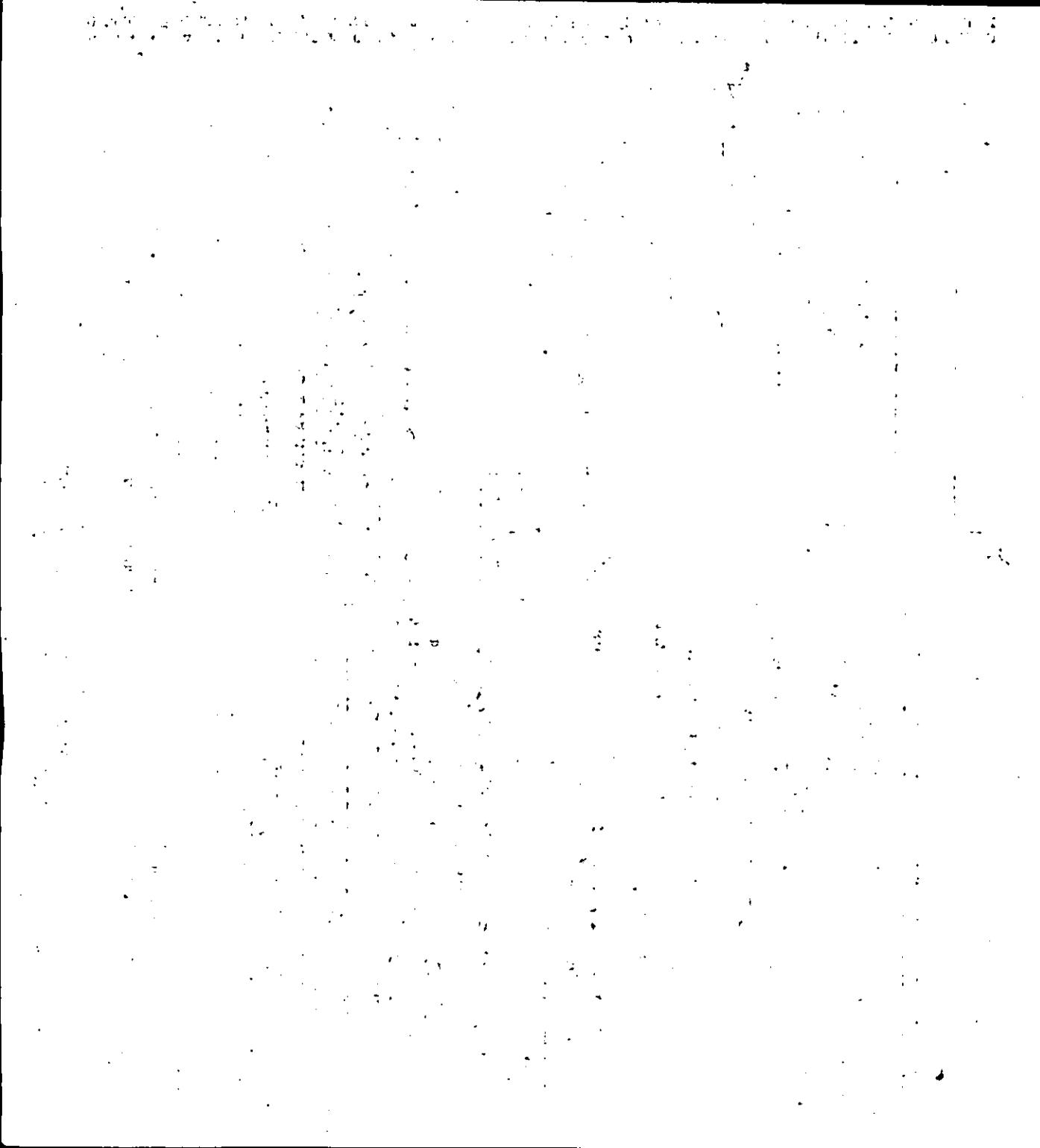
(Address) Oran Mo

*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 Catholic Cemetery DATE OF BURIAL 5/6 1935

20. UNDERTAKER None ADDRESS _____

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.



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CERTIFICATE OF DEATH**

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1. PLACE OF DEATH

County Scott
Township Oram
City Oram (No. _____)

Registration District No. 820
Primary Registration District No. _____

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

2. FULL NAME

Emanuel Mence

(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

MEDICAL CERTIFICATE OF DEATH

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.
63 3 15

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

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

13. NAME _____

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

15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED 6/9 1925 E. P. Chman Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 4 1921

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____. I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance: Fractured hip

Date of onset _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide. Accident Date of injury _____, 1921

Where did injury occur? Scott Co. (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. on farm

Manner of injury Fall

Nature of injury Fracture hip

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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JUN 16 1935