

REC'D JUN 8 1939

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

18762

Do not use this space.

1. PLACE OF DEATH *Walt* <sup>n</sup> Registration District No. *372*  
 (a) County *Walt* Primary Registration District No. *428* Registered No. *1009*  
 (b) Township  
 (c) City *Mount City* (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., (if of foreign birth?) yrs. mos. ds.
2. PRINT FULL NAME *50 Mrs Kate Bunker*  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

- |  |  |   |   |  |
|--|--|---|---|--|
| 3. SEX<br><i>Female</i>  | 4. COLOR OR RACE<br><i>White</i>   | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)<br><i>Widowed</i> |   |  |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____ |  |   |   |  |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>June 13 1856</i>        |  |   |   |  |
| 7. AGE   | YEARS<br><i>82</i>   | MONTHS<br><i>10</i>   | DAYS<br><i>24</i>                               | If LESS than 1 day, _____ hrs. or _____ min. |
| OCCUPATION   | 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <i>House work</i> |   |   |  |
|  | 9. Industry or business in which work was done, as 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) *Washington Co, Penn*13. NAME *Thomas Gourley*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Penn*15. MAIDEN NAME *Hester Blith*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Penn*17. INFORMANT *Mrs Fred Bunker*  
(ADDRESS) *Bigelow, mo*18. BURIAL, CREMATION, OR REMOVAL  
PLACE *Mt Hope* DATE *5/18 39*19. FUNERAL DIRECTOR (NAME) (ADDRESS) *F. E. Hoggan*  
*Mount City Mo*20. FILED *May 19 1939*  
*J. C. Hoggan* Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 17 1939*22. I HEREBY CERTIFY, That I attended deceased from *Sept 18 - 38 58* to *May 17 1939*I last saw her alive on *May 17 1939* Death is said to have occurred on the date stated above, at *12:00 p.m.*

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

*Carcinoma of Esophagus and Cardia of Stomach*

Date of onset \_\_\_\_\_

Other contributory causes of importance:

Name of operation *none* Date of \_\_\_\_\_What test confirmed diagnosis *Autopsy* Was there an autopsy? *NO*23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

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

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? *NO*

If so, specify \_\_\_\_\_

(Signed) *F. E. Hoggan*, M. D.3723 (Address) *Mount City Mo*

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RECEIVED

District Health Officer No. 11,  
District Health Officer P.O. 11,

District File Number ----- 11-39-637

Date Filed ----- JUN 7 1930

Vertical text on the right edge of the page, possibly a stamp or reference code.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *W. Crawford*

Licensed Embalmer No..... 1824

P. O. Address..... *Wound City, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

18762  
Do not use this space.

1. PLACE OF DEATH *Holt*  
 (a) County..... *Holt* Registration District No..... *372*  
 (b) Township..... Primary Registration District No..... *42-18*  
 (c) City..... *Mound City* (d) Street No.....  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 2. PRINT FULL NAME *Mrs Kate Bunker*  
 (a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *7* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *wid*  
 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.  
*82 10 24*  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-17-1939*  
 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:  
*Carcinoma of Esophagus and Cardia of Stomach*  
 Date of onset  
 Other contributory causes of importance:  
*H6*  
 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?..... Date of injury....., 19...  
 Where and injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury.....  
 Nature of injury.....  
 24. Was disease or injury in any way related to occupation of deceased?.....  
 If so, specify.....  
 (Signed) *F. E. Hoggans*, M. D.  
 (Address) *Mound City, Mo*

SUPPLEMENTARY  
*Beginning 2 concussions was in car accident*

12. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)  
 FATHER  
 13. NAME  
 14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)  
 MOTHER  
 15. MAIDEN NAME  
 16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)  
 17. INFORMANT..... (ADDRESS)  
 18. BURIAL, CREMATION, OR REMOVAL PLACE  
 19. FUNERAL DIRECTOR..... (ADDRESS)  
 20. FILED....., 19...  
 Local Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY IN YEARS, MONTHS, DAYS, SHOULD BE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

