

Registration District No.

414 Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

- (a) County Jackson
 (b) City or town Martin City, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 47 years (Specify whether
 years, months or days)

In this community 47 years3. (a) PRINT FULL NAME ALICE ARMILDIA KUNTZ3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Henry Kuntz 6. (c) Age of husband or wife if alive 72 years7. Birth date of deceased Mar 1 1873
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
67 0 0 hr. min.9. Birthplace Adessa Mo. A
(City, town, or county) (State or foreign country)10. Usual occupation at home11. Industry or business own home12. Name Walter Sweetser13. Birthplace Harrison Co. Mo. O
(City, town, or county) (State or foreign country)14. Maiden name Nancy Brady15. Birthplace Worth Co. Mo. O
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Mrs C C Klapmeyer(b) Address Martin City, Mo.17. (a) Burial (b) Date thereof Mar 4, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mt. Moriah18. (a) Signature of funeral director E. R. George & Son(b) Address Grandview, Mo.19. (a) (b) !!
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Jackson
 (c) City or town Martin City, Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ✓ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1 at
year 1940 hour 8 minute 40 A.M.21. I hereby certify that I attended the deceased from Feb 8, 1940
1939, to Feb 29, 1940that I last saw her alive on Feb 29, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Central Apoplexy
with degeneration of feet Duration 21 daysDue to Diabetes MellitusDue to 54Other conditions Aspirin with partial relief
(Include pregnancy within 3 months of death)Major findings:
Of operations _____Of autopsy ✓22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____(c) Where did injury occur? _____
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?
_____While at work? _____ (Specify type of place)
(e) Means of injury _____23. Signature R. F. Spang (M. D. or other) !Address Martin City, Mo. Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically

MARB MAR 13 1940

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 _____

Licensed Embalmer No. 3645

P. O. Address Grandview, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6881

Registration District No. 404

Primary Registration District No. 5538

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Martin city
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRIN FULL Alice Armilda Kuntz

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 67 Months 0 Days 0 If less than one day _____ hr. _____ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) H-9-40 (b) Mr. Jos. J. Brennan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month mar day 1st
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature J. Brennan (M. D. or other) _____

Address Martin city _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

S-6881