

Registration District No. 752

Primary Registration District No. 5992

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Ripley Co. Mo.
(b) City or town Doniphan Mo.
(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) 2

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days Life

3. (a) PRINT FULL NAME Abraham M. Bungardner

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

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

7. Birth date of deceased Sept. 15 1894
(Month) (Day) (Year)

8. AGE: Years 92 Months 5 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name unknown 9

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

14. Maiden name unknown

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

16. (a) Informant's own signature J. E. Bungardner

(b) Address _____

17. (a) none (b) Date thereof Sept 9 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director neighbors

(b) Address _____

19. (a) 3-9-1940 (Date received local registrar) J. J. Krages (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ripley

(c) City or town 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 8th
year 1940 hour 5:30 minute _____ M.

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

Immediate cause of death _____ Duration _____

Death without medical attendance

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 200 ft

Major findings: Of operations _____

Of autopsy _____ PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 job) (Specify cause of injury)

23. Signature Clifford Jofout (M. D. or other) MD

Address Doniphan Mo. Date signed 3/8/40

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.

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.

RECEIVED

District No. **5**

District File No. **440 364**

Date Filed **4340**

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 12 193

Registration District No. 752

Primary Registration District No. 5993

Registrar's No. _____

1. PLACE OF DEATH

(a) County Ray
(b) City or town Ray
(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) PRINT FULL NAME Abraham M Baumgardner

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

4. Sex m 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 Sept 15 18 48
(Month) (Day) (Year)

8. AGE: Years 92 Months 5 Days 2 If less than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-9-40 (b) G. G. Sprague
(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.

20. DATE OF DEATH Mar 8 1940
month day year 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)
(c) Means of injury _____

23. Signature Steph _____ (or other)
Address Douglas _____ date signed _____

SUPPLEMENTARY

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

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

1940
5-12193