JUL 15 1940

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

21358
Do not use this space.

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1. PLACE OF DEATH

(a) County Callaway — Registration District No. 104

(b) Township — Primary Registration District No. 3008 — Registered No. 152

(c) City or Fulton Mo — (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.

5 24

2. PRINT FULL NAME Ruth Munsell

(a) Residence, No. ..... St. ☐ .....
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: T. S. Munsell

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Feb 13, 1882

7. AGE: YEARS 58 — MONTHS 3 — DAYS 26 — If LESS than 1 day, ... hrs. or ..... min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Minneapolis Minnesota

FATHER
13. NAME: Millard F. Bowen
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Buffalo N.Y.

MOTHER
15. MAIDEN NAME: Gertrude Morgan
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Buffalo N.Y.

17. INFORMANT (ADDRESS): State Hospital #1 Record Fulton Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Hannibal, Mo. DATE: June 10, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Leo G. Wallace Fulton, Missouri

20. FILED: June 10, 1940 — [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): June 9, 1940

22. I HEREBY CERTIFY, That I attended deceased from January 28, 1940, to June 9, 1940
I last saw her alive on June 9, 1940. Death is said to have occurred on the date stated above, at 11:45 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Strangulation	6-9-40

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Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? Hiatus, Pyrexia, Clinical and Otherwise — Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Suicide — Date of injury 6-9, 1940
Where did injury occur? State Hosp #1 Fulton Missouri
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. State Hospital #1 Fulton Missouri
Manner of injury Hung herself to Door Hinge
Nature of injury Strangulation

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Gill Forman, M. D.
(Address) ~~[illegible]~~ State Hosp #1 Fulton Missouri

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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

Social Security No. = Hospital record shows no record of a number

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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 Leo G Wallace

Licensed Embalmer No. 3373

P. O. Address Fulton Mo.

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

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

S. No. 2B
1—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21358

Registration District No. 104 Primary Registration District No. 3008 Registrar's No.

1. PLACE OF DEATH
(a) County Callaway
(b) City or town Fulton
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town Hannibal
(If outside city or town limits write "RURAL")
(d) Street No. 1104 Paris Av.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Ruth Munnell
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
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 58 Months 3 Days 26 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Aug. 1, 1940 (Date received by local registrar) (b) R. N. Crews (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9 year 1940 hour 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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 place) (e) Means of injury

23. Signature G. H. Formans (M. D. or other)
Address Fulton Date signed

SUPPLEMENTARY