

Registration District No. 534

Primary Registration District No. 4919

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Mo
(b) City or town New Cambria
(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 _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Mo
(c) City or town New Cambria
(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.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16
year 1941 hour 10 minute 30 a.m.
21. I hereby certify that I attended the deceased from Jan 1st 1941 to Jan 16 1941
that I last saw her alive on Jan 16 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Duration 3 w
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

8. (a) PRINT FULL NAME Minnie Elizabeth Bunker

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Nov - 19 - 1859
(Month) (Day) (Year)

8. AGE: Years 81 Months 0 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name William Dwight Roberts
13. Birthplace Walden
(City, town, or county) (State or foreign country)

14. Maiden name Esther Williams
15. Birthplace New York
(City, town or county) (State or foreign country)

16. (a) Informant Mr. Lee Thomas
(b) Address New Cambria Mo

17. (a) Burial (b) Date thereof Jan 18 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New Cambria

18. (a) Signature of funeral director H. J. Williams
(b) Address New Cambria Mo

19. (a) Jan 8 - 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 2-41-278

Date Filed FEB 13 1941

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.....

H. J. Gilleland....., Registered Apprentice No. _____
working under my personal supervision.

Signed H. J. Gilleland.....

Licensed Embalmer No. 4019.....

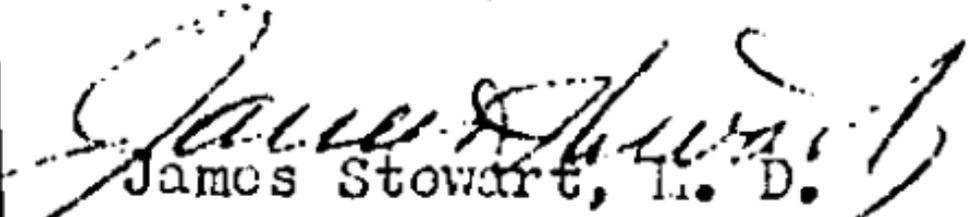
P. O. Address New Cambria Mo......

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.

please fill in no 3a -
last name
Thank you

please write requested information on
back of supplemental and return im-
mediately in the enclosed franked
envelope. Thank you.


James Stewart, L. D.
Special Agent, Bureau of the Census

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3347
Registrar's No.

Registration District No. 534

Primary Registration District No. 4919

1. PLACE OF DEATH:

(a) County Macon
(b) City or town
(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)

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Minnie Elizabeth Burdick

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

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

(b) Name of husband or wife (c) Age of husband or wife if alive years

7. Birth date of deceased Dec 19, 1859
(Month) (Day) (Year)

8. AGE: Years 81 Months 0 Days 18 (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. (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Feb 8, 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19.....
that I last saw him/her 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 (M. D. or other)

Address Date signed

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.