

No. 2
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X-29484

FILED JAN 30 1942
448451

Registration District No.

Primary Registration District No. 5616

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town St. Louis no Cedar on Turp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 Missouri (b) County Dallas
(c) City or town Celt mo
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME RICHARD CHESTER BUMGARDNER

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

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased July 17 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 5 23 hr. min.

9. Birthplace Celt mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation ✓

11. Industry or business.....

MOTHER FATHER

12. Name James H. Bumgardner

13. Birthplace St. Louis 0
(City, town, or county) (State or foreign country)

14. Maiden name Kate C. Madison

15. Birthplace Lynchburg Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant James H. Bumgardner
(b) Address Celt Mo

17. (a) burial (b) Date thereof Jan 12 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director No Funeral Director
(b) Address ✓
19. (a) Jan 20-1942 (b) Grace Rogov
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10
year 1942 hour 7 minute AM

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.....
.....

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?
.....
(Specify type of place) (Means of injury)

23. Signature Claude E. Curtis (M. D. or other)
Address Pres. Atty Debaun Date signed 1-19-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No.

District File Number 1-42-36

Date Filed 1-23-42

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

No Embalming
working under my personal supervision.

....., Registered Apprentice No.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2655
Registrar's No.

Registration District No. 451

Primary Registration District No. 5616

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Rural
(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 Richard C. Bungardner

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 8

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

7. Birth date of deceased July 17, 1942
(Month) (Day) (Year)

8. AGE: Years _____ Months 5 Days 13 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day _____
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 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 Cardiac failure Duration _____

Due to Heart disease

Due to _____

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

Major findings: Of operations 932

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

5-2655