

FILED MAY 15 1943

Registration District No. 314

Primary Registration District No. 6062

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Vista
(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 All of Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair
(c) City or town Vista
(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

Charles H. Bungarden

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary Bungarden

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased AUGUST 28 1873
(Month) (Day) (Year)

8. AGE: Years 69 Months 8 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace St. Clair County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business George Bungarden

12. Name Unknown

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

14. Maiden name _____

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

16. (a) Informant Osceola Missouri

(b) Address Burial
17. (a) (Burial, cremation, or removal) (b) Date thereof May 2-1943
(Month) (Day) (Year)

(c) Place: burial or cremation Kings Prairie

18. (a) Signature of funeral director Osceola Funeral Home

(b) Address Osceola Mo.

19. (a) 4-30-43 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1943 hour I minute A 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 Heart Block- Myocarditis Hypertension

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 [Signature] (M. D. or other) _____
Address Osceola Mo. Date signed 4-30-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

RECEIVED

District Health Officer No. 7,

District File Number 4-43-233

Date Filed 5-11-43

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

Paul D. Stone

Licensed Embalmer No.

3990

P. O. Address

Osceola 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, fact should be so stated above.