

Registration District No. **71**

Primary Registration District No. **3012**

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 mos. 2 days
(Specify whether years, months or days) 11 mos. 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3710 Monroe
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country /

3. (a) PRINT FULL NAME Joe V. Tunstall
3. (b) If veteran, name war World War II 3. (c) Social Security No. 566-12-6615

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Margaret Tunstall
6. (c) Age of husband or wife if alive 30 years
7. Birth date of deceased April 11, 1914
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
29 3 18 hr. min.

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

10. Usual occupation None

11. Industry or business II

12. Name Joe Tunstall
13. Birthplace Lexington Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Hazel Phares
15. Birthplace Kansas City Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records, Veterans Administration, Excelsior Springs, Mo.
(b) Address Excelsior Springs, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-29-43
(Month) (Day) (Year)
(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director HERBERT HOPE
(b) Address Excelsior Springs, Mo.

19. (a) 7-29-43 (Date received local registrar) (b) Missade Redman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29
year 1943 hour 4:50 minute A. M.

21. I hereby certify that I attended the deceased from August 27, 1942 to July 29, 1943;
that I last saw him alive on July 29, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, Pulmonary, Chronic, far advanced, active, 4 severe

Due to 13 fl

Other conditions Empyema, tuberculous, right chest

Major findings:
Of operations ---
Of autopsy No 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 FORREST G. BELL, M.D. (M. D. or other)
Address Veterans Administration Date signed 7-29-43
Excelsior Springs, Mo.

Duration

Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

12-7-42

7-29-43

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

RECEIVED

District Health Officer No. 3

District File Number

Date Filed

9-3-43

AUG 19 1950

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.....

Licensed Embalmer No. 3296

P. O. Address. Ex App 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.