

AUG 23 1943
Registration District No. ~~112~~ 129

Primary Registration District No. 5466

1. PLACE OF DEATH: **GREENE**

(a) County. **RURAL**

(b) City or town. **Springfield S. Campbell Twp.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **MEDICAL CENTER FOR FEDERAL PRISONERS**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 mos., 11 days**
(Specify whether years, months or days)

In this community **3 mos., 11 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Florida** (b) County. **Hillsborough**

(c) City or town. **Tampa**
(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. **1**

3. (a) PRINT FULL NAME. **MUNCH, George A.**

3. (b) If veteran, name war. **unk.**

3. (c) Social Security No. **unk.**

4. Sex **male**

5. Color or race. **white**

6. (a) Single, widowed, married, divorced. **3 divorced**

6. (b) Name of husband or wife. **unk.**

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

7. Birth date of deceased. **April 29 1862**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	81	3	13	hr. min.

9. Birthplace. **Fremont Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation. **Physician**

11. Industry or business.

12. Name. **George Munch**

13. Birthplace. **unknown Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name. **unknown**

15. Birthplace. **unk. Canada**
(City, town, or county) (State or foreign country)

16. (a) Informant. **File**

(b) Address. **Medical Center, Springfield, Mo.**

17. (a) **Removal** (b) Date thereof. **Aug. 15, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. **Fremont, Ohio**

18. (a) Signature of funeral director. **H.H. Lohmeyer**

(b) Address. **Springfield, Mo.**

19. (a) **8-14-43** (b) **W. Handley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **12**
year **1943** hour **12** minute **18** P.M.

21. I hereby certify that I attended the deceased from **May 1st, 1943** to **August 12, 1943**.
that I last saw him alive on **August 12, 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death. **Cerebral embolism**

Due to **arteriosclerosis** prior to admission

Due to **senility**

Other conditions. **tumor, sigmoid region** prior to admission
(Include pregnancy within 3 months of death)

(adenocarcinoma), psychosis, senile. PHYSICIAN

Major findings:
Of operations.
Of autopsy.
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).....
Date of occurrence.....

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. **0**

23. Signature. **H. Cox** (M.D. ~~attester~~)
Address. **Supt. & Chief Medical Officer** signed **8-13-43**

Medical Center for Federal Prisoners
Springfield, Mo.

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

MOTHER FATHER

954

(Licensed Embalmer's Statement on Reverse Side)

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 J. Henry
.....
Licensed Embalmer No. *2047*

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.