

FILED JAN 18 1944

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 21

1. PLACE OF DEATH:

(a) County W. Va.
(b) City or town Willsboro, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Loughery Hospital (1)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Dec 17 1943
to Jan 10 1944 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Bunch, Miss Alta

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married 0 divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 16 1897
(Month) (Day) (Year)

8. AGE: Years 56 Months 6 Days 25 If less than one day hr. _____ min. _____

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

10. Usual occupation School Teacher

11. Industry or business _____

MOTHER FATHER { 12. Name Cery Bunch
13. Birthplace Mo (City, town, or county) (State or foreign country)
14. Maiden name Martha Cook
15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant Rose Saunders
(b) Address Zablato, Mo
17. (a) Burial (b) Date thereof Jan 12 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Zablato
18. (a) Signature of funeral director D. S. Christie
(b) Address Zablato, Mo
19. (a) 1/13/44 (b) Mrs. J. W. Wagner
(Date received/local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon
(c) City or town Zablato
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10
year 1944 hour 2 minute 15 P. M.

21. I hereby certify that I attended the deceased from Dec 17, 1943
to Jan 10, 1944, to _____, 19____;
that I last saw h. _____ alive on Jan 10, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Dead in hospital Duration _____
due to coronary artery
obstruction.
Due to operation on Dec 17
for fracture of femur.
Due to _____

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

Major findings:
Of operations _____

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 ✓
Signature Dr. W. L. Wagner (M. D. or other) DO
Address Zablato, Mo Date signed Jan 11

1049

1144 / 216

JAN 18 1944

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 D. S. Christie

Licensed Embalmer No. 1109

P. O. Address La Plata 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1871

Registration District No. 1

Primary Registration District No. 2000

Registrar's No. 21

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kennett
(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 Alta Burch
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 5
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 16 1860
(Month) (Day) (Year)

8. AGE: Years 56 Months _____ Days _____ If less than one day _____ min.

9. Birthplace Ms.
(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) Date thereof _____ (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 Dec Day 17 Year 1943 Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
1860
31

PHYSICIAN _____
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 Dec 17 1943
(c) Where did injury occur? In Plateau Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? slipped on ice, crossing street (Specify type of place) (e) Means of injury _____
While at work? _____ (e) Means of injury _____
23. Signature Wm R. Gallagher (M. D. or other) DO
Address Kenett Mo Date signed Dec 19 1943

SUPPLEMENTARY

MOTHER FATHER

