

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26012**

FILED AUG 11 1944

Registration District No. **374**

Primary Registration District No. **6276**

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County **North**
(b) City or town **Rural - Union**
(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 **8 yrs.**
years, months or days

3. (a) PRINT FULL NAME **Marion Dale Lamunyon**

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

4. Sex **0 m** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **avg**, **13**, **1944**
(Month) (Day) (Year)

8. AGE: Years **17** Months **10** Days **5** If less than one day _____ hr. _____ min.

9. Birthplace **Laurel** **Okla.**
(City, town, or county) (State or foreign country)

10. Usual occupation **farmer**

11. Industry or business _____

12. Name **J. C. LaMunyon**

13. Birthplace **North Co. Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Maudie LaMunyon**

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

16. (a) Informant **J. C. LaMunyon**

(b) Address **Grant City, Mo.**

17. (a) **Burial** (b) Date thereof **6-21-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mr. Vernon Can.**

18. (a) Signature of funeral director **Arch C. Dunfee**

(b) Address **Grant City, Mo.**

19. (a) **July 10 - 1944** (b) **Anna Scadden**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **North**
(c) City or town **Rural** **113**
(If outside city or town limits, write "RURAL")

(d) Street No. **Grant City, Mo.** **5**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country **U**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **18**
year **1944** hour **6** minute **30 P.M.**

21. I hereby certify that I attended the deceased from _____ to _____

that I last saw him alive on _____ 19 _____

and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Drowned in W.P.A. pond
at 11:30 water 2 1/2 hours

Due to **cramps while**

swimming

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) **accident !!!**

(b) Date of occurrence **6-18-44**

(c) Where did injury occur? **Shelton North - Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

W.P.A. pond
(Specify type of place)

While at work? **swimming** (e) Means of injury **3 carover**

23. Signature **A. C. Dunfee** (Ink or other)

Address **Grant City, Mo.** Date signed **6-19-44**

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

Arch C. Duffee

Licensed Embalmer No.....

3252

P. O. Address.....

Grant City, 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.