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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27492**

FILED SEP 13 1945
Registration District No. **139**

Primary Registration District No. **5535**

Registrar's No. **50**

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

1. PLACE OF DEATH:
 (a) County Holt
 (b) City or town New Point-Rural Hickory
(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 Lifetime
years, months or days

3. (a) PRINT FULL NAME James Moses Kunkel
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____
4. Sex Male **5. Color or race** White
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 January 4 1871
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 12
 If less than one day _____ hr. _____ min.

9. Birthplace Holt Co. Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer

11. Industry or business
12. Name Benjamin Franklin Kunkel
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Hannah Chester
15. Birthplace Holt Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Carl Kunkel
(b) Address New Point, Missouri
17. (a) Burial **(b) Date thereof Aug. 24 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New Point, Missouri**

18. (a) Signature of funeral director J. P. Pettigrew
(b) Address Oregon Mo.
19. (a) 8-28-45 **(b) Pauline Sawson**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Holt
 (c) City or town New Point-Rural
(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 August day 22
 year 1945 hour 4 minute 30 P.
21. I hereby certify that I attended the deceased from Aug 19, 1945, to Aug 22, 1945;
 that I last saw him alive on Aug 21, 1945,
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
 Duration 2 days

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
Major findings:
 Of operations Cerebral
 Of autopsy none
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) none
 (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 stroke
23. Signature E. F. Hurd (M. D. or other) _____
 Address 1029 E. Main St. MO Date signed Aug 28/45

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 *James H. Pettigrew*
.....
Licensed Embalmer No. *3192*
.....
P. O. Address *Oregon 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.