

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 9 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23170**

Registration District No. **99** Primary Registration District No. **4172** Registrar's No. **57**

1. PLACE OF DEATH:
(a) County **De Kalb**
(b) City or town **Stewartsville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) county **De Kalb**
(c) City or town **Stewartsville, Mo.**
(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 _____

3. (a) PRINT FULL NAME **Martha Jane GUNN**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. **DATE OF DEATH:** Month **July** day **17th** year **1946** hour **11** minute **30 P.** M.
21. I hereby certify that I attended the deceased from **April 6**, 19**46** to **July 7**, 19**46** that I last saw her alive on **July 7**, 19**46** and that death occurred on the date and hour stated above.

4. Sex **Feminine** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, widowed
(b) Name of husband or wife **Albert Gunn** 6. (c) Age of husband or wife if alive, _____ years
7. Birth date of deceased **October 2, 1865**
(Month) (Day) (Year)

Immediate cause of death **Pulmonary Edema**
Due to **Myocarditis**
Due to **Myocarditis**

8. AGE: Years **80** Months **9** Days **5** hr. _____ min. _____

Other conditions **Semiplegia & Hypertension**
Major findings: Of operations _____
Of autopsy **9/3/46**

9. Birthplace **Near Lower Buchanan Co.** (City, town, or county) (State or foreign country)
10. Usual occupation **House-keeping**

MOTHER FATHER
11. Industry or business _____
12. Name **William Price Witt**
13. Birthplace **Clay County, Mo.** (City, town, or county) (State or foreign country)
14. Maiden name **Mary Anna McRae**
15. Birthplace **Bedford, Tennessee** (City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs Ethel Goodwin**
(b) Address **Stewartsville Mo.**
17. (a) _____ (b) Date thereof **June 9 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Highland Mo.**

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? _____

18. (a) Signature of funeral director **W. P. Taylor**
(b) Address **Stewartsville Mo.**
19. (a) **7-16-46** (b) **R. A. Schenck**
(Date received local registrar) (Registrar's signature)

While at work _____ (Specify type of place) (c) Means of injury _____
23. Signature **W. P. Taylor** (Date signed **7-9-46**)
Address **Stewartsville Mo.**

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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

E. G. Jones

Licensed Embalmer No.

952

P. O. Address

Stewartville 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.