

No. 2
 1947-30
 237823
 ST-100
 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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Registration District No. 39 Primary Registration District No. 5121

1. PLACE OF DEATH:
 (a) County Boone
 (b) City or town Rural Persche
(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
 In this community 2 6 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Macon
 (c) City or town Bevier Mo.
(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 JOSEPH R. BURGE
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 13
 year 1947 hour 6:00 minute _____ M.

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, 2 divorced, widowed
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept. 11 1872
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 15
1946 to Aug 15 1946
 that I last saw him alive on Aug 15 1946
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>7</u>	<u>2</u>	hr. _____ min. _____

Immediate cause of death
Apoplexy 2 hours
Septicemic meningitis
 Due to _____
 Due to _____

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

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

10. Usual occupation Farmer

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Robert Williams

(b) Address 322 McBaine

17. (a) Burial (b) Date thereof 3 15 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Red Rock Cem.

18. (a) Signature of funeral director Parker Funeral Service

(b) Address Columbia Mo.

19. (a) 4-9-47 (b) Mrs. Roland Hamb
(Date received local registrar) (Registrar's signature)

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 0

23. Signature F B Williamson M.D. or other _____

Address Columbia Mo. Date signed 3-15-47

Issue burial
permit sent to
Jeff for certified copy

MAR 31 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 Tom McHarg

Licensed Embalmer No. 4062

P. O. Address Columbia, 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.

Registration District No. 39 Primary Registration District No. 5121

1. PLACE OF DEATH:

(a) County Boone Rural
(b) City or town Rural
(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 _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME

Joseph R. Bunge

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced and

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

7. Birth date of deceased Sept 11 (Month) (Day) (Year)

8. AGE: Years 74 Months 7 Days _____ (If less than one day) hr. min.

9. Birthplace _____ (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) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-9-1947 (b) Miss Roland Homber (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 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)

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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-7880