

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25394**
Registrar's No. **798**

FILED SEP 7 1948

Registration District No. **11**

Primary Registration District No. **4025**

1. PLACE OF DEATH:
(a) County **Barry**
(b) City or town **Wheaton, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **None**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **28 yrs.** (Specify whether years, months or days)

3: (a) PRINT FULL NAME **Isiac E. Bunnell**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Betsy Bunnell** 6. (c) Age of husband or wife if alive **66** years
7. Birth date of deceased **October 1 1868**
(Month) (Day) (Year)

8. AGE: Years **79** Months **10** Days **24** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Carpenter**

11. Industry or business **Carpenter**

12. Name **James E. Bunnell**

13. Birthplace **New York**
(City, town, or county) (State or foreign country)

14. Maiden name **Not Known**

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

16. (a) Informant **Mrs Betsy Bunnell**

(b) Address **Wheaton, Mo.**

17. (a) **Burial** (b) Date thereof **8-27-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **I.O.O.F. Cem Neosho, Mo.**

18. (a) Signature of funeral director **W. Marie Boye**
(b) Address **Wheaton, Mo.**

19. (a) **Aug 26-1948** (b) **Grace Williams**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Barry**
(c) City or town **Wheaton**
(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 **August** day **24**
year **1948** hour **3** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Aug-20**
_____ 1948 to **Aug-24** 1948
that I last saw h _____ alive on _____, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **4 days**
Due to **Arterio Sclerosis** **29 yrs.**

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 **O. S. McCall** (M. D. or other)
Address **Wheaton Mo.** Date signed **8-25-48**

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

5060

RECEIVED

District Health Officer No. 6,

District File Number 948-994

Date Filed SEP 3 1948

SEP 3 1948

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

Wm Maria Payne

Licensed Embalmer No. 38427

P. O. Address

Wheaton, Md

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.