

THE DIVISION OF HEALTH OF MISSOURI  
FILED JAN 26 1949 STANDARD CERTIFICATE OF DEATH

State File No. 3696

BIRTH NO. _____		REG. DIST. NO. 325		PRIMARY REG. DIST. NO. 4478		Registrar's No. 3	
1. PLACE OF DEATH a. COUNTY SCHUYLER				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY SCHUYLER			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN LANCASTER		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN LANCASTER, MO		98	
d. FULL NAME OF HOSPITAL OR INSTITUTION LANCASTER, MO				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) ISABELL		a. (First)		b. (Middle) BUNCH		c. (Last)	
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH JAN 1, 1855	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 94		11. BIRTHPLACE (State or foreign country) MISSOURI	
13a. FATHER'S NAME JOHN Mc GLODRICK		13b. MOTHER'S MAIDEN NAME JANE LEEDOM		14. NAME OF HUSBAND OR WIFE		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME W. F. Bunch		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anemia with nutritional failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senile Dementia DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 8 years 8 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 3, 1935, to Jan 15, 1949, that I last saw the deceased alive on Jan 15, 1949, and that death occurred at 6:30 P.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Edw. M. Nailton, M.D.				23b. ADDRESS Lancaster, Mo.		23c. DATE SIGNED 1-17-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JAN 17, 1949		24c. NAME OF CEMETERY OR CREMATORY ARNOLD CEM		24d. LOCATION (City, town, or county) (State) LANCASTER, MO.	
DATE REC'D BY LOCAL REG. Jan 22/49		REGISTRAR'S SIGNATURE Mrs. A. J. Drake		358		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Everett R. Head Lancaster, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
District Health Officer No. 10  
Office File Number 149-146  
Date Filed JAN 24 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....

Student Embalmer

Signed

*Everett R. Head*

Licensed Embalmer No. 4038

P. O. Address *Lancaster, 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.