

FILED JUN 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **15669**BIRTH NO. _____ REG. DIST. NO. 139 PRIMARY REG. DIST. NO. 030 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY Holt		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Holt	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mound City Rural		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Forest City	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) Rural	
3. NAME OF DECEASED (Type or Print) a. (First) Samuel		b. (Middle) B	
c. (Last) Kunkel		4. DATE OF DEATH (Month) (Day) (Year) May 23, 1949	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 10/2/1864
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Holt County, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John Kunkel	
13b. MOTHER'S MAIDEN NAME Rebekah Secrist		14. NAME OF HUSBAND OR WIFE Effie Woods Kunkel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Effie Kunkel		ADDRESS Forest City, Mo.	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF STOMACH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. MITRAL STENOSIS	
INTERVAL BETWEEN ONSET AND DEATH 10 Mo.		151X UNKNOWN	
19a. DATE OF OPERATION NONE		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) NO		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) NO		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 JUN , 1947, to MAY 23, 1949 , that I last saw the deceased alive on MAY 2, 1949 , and that death occurred at 10:45 PM. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) H. E. Colkin A.B. D.O. 2		23b. ADDRESS Oregon Mo.	
23c. DATE SIGNED MAY 26, 49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5/26/1949	
24c. NAME OF CEMETERY OR CREMATORY Benton cemetery		24d. LOCATION (City, town, or county) (State) Mound City, Mo.	
DATE REC'D BY LOCAL REG. 5-27-49		REGISTRAR'S SIGNATURE J. Chaney	
25. FUNERAL DIRECTOR'S SIGNATURE H. H. [Signature]		ADDRESS Mound City, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

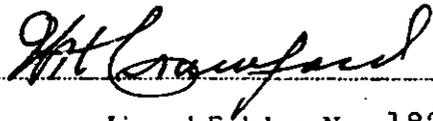
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....



Licensed Embalmer No. 1824

P. O. Address Mound City, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.