

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25143  
6692

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis c. CITY OR TOWN Clayton	
b. CITY OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clayton	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If rural, give location) W.R. - 831 Westwood Drive	

3. NAME OF DECEASED (Type or Print) Albert V.	a. (First)	b. (Middle) M. V. M. M. M.	c. (Last) Munyon	4. DATE OF DEATH August 1st 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed	8. DATE OF BIRTH Nov. 16th 1863	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman	10b. KIND OF BUSINESS OR INDUSTRY Fire Dept.	11. BIRTHPLACE (State or foreign country) Viroqua, Wisconsin	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME William M. Munyon	13b. MOTHER'S MAIDEN NAME Sarah K. Humphrey	14. NAME OF HUSBAND OR WIFE Octavia Schevrell
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. George Thompson 831 Westwood Dr. Clayton Mo.	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2-3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Uremia, Pulmonary Edema</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Carcinoma of Prostate</i> DUE TO (c) <i>General Metas</i>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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? <i>1949</i>
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22. I hereby certify that I attended the deceased from 8/30/49, to 8/1/49, that I last saw the deceased alive on 8/1/49, and that death occurred at 1 p.m., from the causes and on the date stated above.

23a. SIGNATURE <i>Alvin Goldfarb, M.D.</i> (Degree or title)	23b. ADDRESS 6634 N. Grand St. Kansas Mo.	23c. DATE SIGNED 8/1/49
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24a. BURIAL, CREMATION, REMOVAL Burial (Specify)	24b. DATE 8-3-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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DATE REC'D BY LOCAL REG. AUG 1 1949	REGISTRAR'S SIGNATURE <i>J. B. Parson</i>	25. FUNERAL DIRECTOR'S SIGNATURE W. A. Stock 2117 E. Grand St. Louis Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Aug 25 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 Me

working under my personal supervision.

Student Embalmer No.....

Signed.....

Edward H. Pennington

Signed.....  
Student Embalmer

Licensed Embalmer No. 4283

P. O. Address St. Louis, 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.