

FILED MAR 20 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 8883

904

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. JOSEPH MO. 0117	
c. LENGTH OF STAY (in this place) 10 days		d. STREET ADDRESS (If rural, give location) 1916 Dewey Ave	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) William c. (Last) Muench			4. DATE OF DEATH (Month) (Day) (Year) Feb. 27 1950			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH May 9, 1895	9. AGE (In years last birthday) 54	10. UNDER 1 YEAR 7	11. UNDER 1 HRS. 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRUGGANT		10b. KIND OF BUSINESS OR INDUSTRY AUTO STORE		11. BIRTHPLACE (State or foreign country) ST. JOSEPH, MO. 0		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME ALBERT C. MUENCH	13b. MOTHER'S MAIDEN NAME IDA HAUCK	14. NAME OF HUSBAND OR WIFE GERTRUDE B. MUENCH
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes WW#1	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME MRS GERTRUDE B. MUENCH	ADDRESS NORTH PLATE, NEAR
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma pancreas		INTERVAL BETWEEN ONSET AND DEATH 5 mos.
	ANTECEDENT CAUSES Morbidity 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. metastases to liver 15th		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 Nov. 15, 1949, to Feb 27, 1950, that I last saw the deceased alive on Feb 26, 1950, and that death occurred at 6:15 a. m., from the causes and on the date stated above.

23a. SIGNATURE William F. Sanders M.D.	23b. ADDRESS 1103 Grand Kansas City, Mo	23c. DATE SIGNED Feb 27, 1950
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removed	24b. DATE 2/27/50	24c. NAME OF CEMETERY OR CREMATORY -	24d. LOCATION (City, town, or county) (State) St. Joseph Mo
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DATE REC'D BY LOCAL REG. 2-27-50	REGISTRAR'S SIGNATURE Maaldine Helma Heaton-Bowman	25. FUNERAL DIRECTOR'S SIGNATURE 349 So 10th St. Joseph, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 20 1950

JUL 1 9 1961

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th, St. Joseph, 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.