

FILED SEP 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

26363

3358

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		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 Jackson			
b. CITY OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 65 Yrs.		c. CITY OR TOWN Kansas City		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital				STREET ADDRESS (If rural, give location) 46 3143 Bell Street			
3. NAME OF DECEASED (Type or Print) a. (First) WILLARD			b. (Middle) B.		c. (Last) MUNDEN		4. DATE OF DEATH (Month) (Day) (Year) Aug. 2, 1955
5. SEX Male	6. COLOR OR RACE White	7. MARRIED; NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Feb. 18, 1871	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Millwright		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Jackson County, Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Jacob Munden		13b. MOTHER'S MAIDEN NAME Larinda Smallwood		14. NAME OF HUSBAND OR WIFE Ida B. Munden			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 513-09-1661A		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Anna E. Cog K. C. 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) renal Acute cystitis with asthenia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis heart DUE TO (c) Arteriosclerotic disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 week 605X	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" 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 <u>4-19</u> , 19 <u>46</u> , to <u>8-2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-2</u> , 19 <u>55</u> and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE Sherry Ann Cog (Degree or title) 0				23b. ADDRESS 1120 S. 42nd K.C.K.		23c. DATE SIGNED 8-3-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-4-55	24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.		
DATE REC'D BY LOCAL REG. 8-3-55		REGISTRAR'S SIGNATURE Neva Marshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Freeman Mortuary K. C. Mo.			

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

The Spring House

1420 S. 42

H.C.H.

11-

1906 also

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.....
Signature of Student Embalmer

Signed *Clayton K Barnes*

Licensed Embalmer No. *479*

P. O. Address *K.C.H.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.