

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**13906**

STATE FILE NUMBER

**FILED APR 22 1957**

Registration District No. 100 Primary Registration District No. 5725 Registrar's No. 52

Health,  
Welfare  
Public  
Service

300) 610  
1-56 4

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>Macon Hudson</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Milan</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION <u>LakeView R. Home</u> <u>6 mo</u>		d. STREET ADDRESS <u>1050</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Perry S Bunch</u> First Middle Last		4. DATE OF DEATH <u>4 4 1957</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-1868</u>
9. AGE (In years last birthday) <u>88</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	
11. BIRTHPLACE (City and state or country) <u>La Plata - Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Joseph Bunch</u>		14. MOTHER'S MAIDEN NAME <u>Mary J Gross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Ora Bunch</u>		Address <u>Milan Mo</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Statis Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Fracture of the Left Femur (neck)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 wks</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION <u>661</u>		COUNTY STATE	
21. I attended the deceased from _____ to <u>4-4-57</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>4-3-57</u> Death occurred at <u>HOME</u> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>A. L. Burden D.O.</u> (Degree or title)		22b. ADDRESS <u>Macon</u>	
22c. DATE SIGNED <u>4-5-57</u>			
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE <u>4-5-57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Milan Mo</u>	
24. FUNERAL DIRECTOR <u>Schoenes Dwight Schoenes</u>		25. DATE RECD. BY LOCAL REG. <u>4/6/57</u>	
ADDRESS <u>Milan Mo</u>		26. REGISTRAR'S SIGNATURE <u>Ruth McNeely</u>	

(Licensed Embalmer's Statement on Reverse Side)

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MACON CO. GA.  
County File No. 457-2  
Date Filed 4-18-57

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 *Dwight Schoene*.....

Licensed Embalmer No. *2467*

P. O. Address *Nolan - N*

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.