

FILED JUL 1 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20089  
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 687

300  
-57  
0

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Savannah</u> <u>0020</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Methodist Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>108 W. Main St.,</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay in lb <u>4 days</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Bunse</u>			4. DATE OF DEATH Month <u>June</u> Day <u>20,</u> Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>May 10, 1873</u>
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware&amp;Implement</u>	11. BIRTHPLACE (City and state or country) <u>Cosby, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Schroeder</u>	14. NAME OF HUSBAND OR WIFE <u>Eva T. Bunse</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>494-40-8425</u>	17. INFORMANT Address <u>Elmer Bunse, St. Joseph, 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>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Embolism</u> DUE TO (c) <u>Atrial Fibrillation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u> <u>4 days.</u> <u>2 years.</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>332x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 COUNTY STATE
21. I attended the deceased from <u>12-28-51</u> to <u>6-29-57</u> and last saw him alive on <u>6-19-57</u> Death occurred at <u>4:15</u> pm on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert B. Kelley, M.D.</u>		22b. ADDRESS <u>Savannah, Mo.</u>	22c. DATE SIGNED <u>6-24-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 23, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>E.U.B. Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Cosby, Missouri.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Meierhoffer-Fleeman Inc. St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>June 26, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Robert Fulton</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MS APR 28 1960

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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 *Albert B. Harrington* .....

Licensed Embalmer No. 3258 .....

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