

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001275
STATE FILE NUMBER

FILED JAN 27 1959

Registration District No. 155- Primary Registration District No. 3127 Registrar's No. 13

300
-57

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) Webb City		c. CITY OR TOWN Joplin	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jane Chinn		d. STREET ADDRESS (If outside, give location) 717 Ohio	
3. NAME OF DECEASED (Type or print) First Middle Last Walter S. Bunea		4. DATE OF DEATH Month Day Year Jan. 18, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Detroit, Michigan
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Nellie May Bunea
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. 378-03-5525	17. INFORMANT Nellie May Bunea
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 8 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
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 <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 1/11/1959 to 1-18-59 and last saw him alive on 1/18/1959 Death occurred at 2:25 P.M. 2:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE E.O. Martin, D.O.		22b. ADDRESS 709 Joplin, Joplin, Mo.	
		22c. DATE SIGNED 1/19/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 20, 1959	
23c. NAME OF CEMETERY OR CREMATORY Forest Park		23d. LOCATION (City, town, or county) (State) Joplin, Missouri	
24. FUNERAL DIRECTOR Thornhill-Dillon Joplin, Mo.		25. DATE RECD. BY LOCAL REG. 1-20-59	
		26. REGISTRAR'S SIGNATURE Mrs. Madeline Switzer	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 All diseases in Part I must be causally related.
 E.O. Martin-D.O.

FEB 11

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 *Robert C. Koller*

Licensed Embalmer No. *5062*

P. O. Address *Joplin, 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.