

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004228

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 22

FILED FEB 10 1959

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Vernon</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Nevada</b> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Nevada</b> 1080 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>614 N. Washington</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>614 N. Washington</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Flora</b> Middle <b>Eunice</b> Last <b>Kunkel</b>			4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1959</b>		
5. SEX <b>Fm</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 23, 1873</b>	9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min. <b>85</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (City and state or country) <b>Warrensburg, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>David R. Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Lavina Clark</b>		14. NAME OF HUSBAND OR WIFE <b>C. E. Kunkel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. L. C. Bruce, 9108 Vaughn, Missouri</b> Address <b>Kansas City, 33</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized arteriosclerosis</b>	<b>Unknown</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) <b>Interval stroke</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>

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 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 <b>Nevada</b>	COUNTY <b>Missouri</b>	STATE
21. I attended the deceased from <b>Nov. 17, 1958</b> to <b>Jan. 27, '59</b> and last saw her alive on <b>Jan. 26, 1959</b> Death occurred at <b>Nevada, Missouri</b> <b>4:00 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>D. P. McCann, M.D.</b>	22b. ADDRESS <b>Moore Building, Nevada, Mo.</b>	22c. DATE SIGNED <b>1-29-1959</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Deerwood Cemetery</b>	23d. LOCATION (City, town, or country) (State) <b>Nevada Missouri</b>
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24. FUNERAL DIRECTOR <b>Ferry Funeral Home Nevada, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>2-2-1959</b>	26. REGISTRAR'S SIGNATURE <b>Ormal E. Ferry</b>
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(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *L. Stephen Jones* .....

• Licensed Embalmer No. *4960* .....  
P. O. Address *Missoula* .....

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.