

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018048

Registration District No. 146 Primary Registration District No. 3026 STATE FILE NUMBER Registrar's No. 247

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Independence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Independence</b> 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>Cable Rest Home</b>		Length of stay in lb <b>Life</b>	700 <sup>5</sup> / <sub>0</sub> STREET ADDRESS <b>1423 N. Main</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>MR. ALLEN EDWARD BUNYAR</b>			4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1901</b>	9. AGE (In years last birthday) <b>57</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Florist</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Independence, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Edward G. A. Bunyar</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Barnhard</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Gladys Bunyar</b>
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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>490-090-496</b>	17. INFORMANT <b>Mrs. Gladys Bunyar, Indep., Mo.</b>	Address
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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 - Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized arteriosclerosis</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>malignant hypertension</b>		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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year	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 COUNTY _____ STATE _____
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21. I attended the deceased from <b>1958</b> to <b>1959</b> and last saw <sup>him</sup> alive on <b>May 15, 59</b> Death occurred at <b>approx. 3:30</b> pm on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Paul F. Bachmann MD</b> (Degree or title)	22b. ADDRESS <b>Indep., Mo.</b>	22c. DATE SIGNED <b>5-27-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 28, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington</b>	23d. LOCATION (City, town, or county) (State) <b>K.C., Mo.</b>
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24. FUNERAL DIRECTOR <b>OTT &amp; MITCHELL, Indep., Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-28-59</b>	26. REGISTRAR'S SIGNATURE <b>James L. Craig</b>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

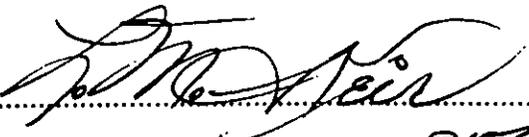
MEDICAL CERTIFICATION

300  
-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  .....

Licensed Embalmer No. 3156 .....  
P. O. Address Edinboro .....

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.