

**IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-031697**

**FILED VS. SEP 22 1959 53**

**3010**

**327**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Cape</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Stoddard</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cape Girardeau</b>		Length of stay in 1b	c. CITY OR TOWN <b>Bloomfield</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>S. E. Mo. Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>---</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>W.</b> Last <b>MUNGER</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>8,</b> Year <b>1959</b>		
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</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>3-9-1871</b>	9. AGE (last birthday) <b>88</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>29</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney at Law</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (City and state or country) <b>Reynolds Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Francis M. Munger</b>		13b. MOTHER'S MAIDEN NAME <b>Salome Parks</b>		14. NAME OF HUSBAND OR WIFE <b>Beulah Munger</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>499-22-5709</b>	17. INFORMANT Address <b>Beulah Munger, Bloomfield, Mo.</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>Severe Cerebral Concussion</b>					INTERVAL BETWEEN ONSET AND DEATH <b>8 hr. 40 min.</b>
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) <b>Confusion of Lungs.</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Auto Accident</b>			
20c. TIME OF INJURY Hour <b>9</b> p.m. Month, Day, Year <b>8 59</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <b>Highway</b>				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. CITY, TOWN, OR LOCATION <b>Bloomfield</b>		COUNTY <b>Stoddard</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>4:00 p.m.</b> to <b>7:40 p.m.</b> and last saw him alive on <b>7:40 p.m. 9-8-59</b> Death occurred at <b>7:40 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Marvin C. Kasten, M.D.</b>			22b. ADDRESS <b>937 Boulevard Cape Girardeau</b>		22c. DATE SIGNED <b>9-12-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Sept. 11-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dexter cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Dexter, Missouri</b>	
24. FUNERAL DIRECTOR <b>CHILES UND.CO. BLOOMFIELD, MO.</b>			25. DATE RECD. BY LOCAL REG. <b>9-16-59</b>	26. REGISTRAR'S SIGNATURE <b>Dune Kasten</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

BS  
SEP 2 1938

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

& by Lulu Cooper # 3499 \_\_\_\_\_, ~~Student Embalmer~~ No. \_\_\_\_\_

working under my personal supervision.

~~XXXXXXXXXXXXXXXXXXXX~~

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Ivan C. Cooper \_\_\_\_\_

Licensed Embalmer No. 4119

P. O. Address Bloomfield, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.