

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000024

FILED VS FEB 8 1960

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 22

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Adair</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Adair</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Length of stay in 1b yrs.		c. CITY OR TOWN <b>Kirksville</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>Community Nuresse Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>815-N-Davis</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <b>MARY L. MUNN</b>				<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>2</b> Year <b>1960</b>									
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>6-18-1868</b>		<b>9. AGE (last birthday)</b> <b>91</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Domestic</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Adair Co. Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A</b>					
<b>13a. FATHER'S NAME</b> <b>Phillip Lambert</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Magdolina Sharr</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>Marion m. Munn (D)</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Kirksville, Mo.</b> <b>Mrs. Lora Morrow, 1065-N-Franklin</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Medullary Failure</b> DUE TO (b) <b>Cerebral Encephalomalacia</b> DUE TO (c) <b>Cerebral Atherosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>months</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								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					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour <b>12:15</b> a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>			
<b>21. I attended the deceased from</b> <b>Sept 1, 1959</b> <b>to</b> <b>Feb 2, 1960</b> <b>and last saw her</b> <b>alive on</b> <b>January 4, 1960</b> Death occurred at <b>12:15</b> <b>A. m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> <i>William F. Burgen, D.O.</i>					<b>22b. ADDRESS</b> <b>Kirksville, Mo.</b>			<b>22c. DATE SIGNED</b> <b>Feb 2 1960</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>2-3-1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Sloans Point Cemetery</b>			<b>23d. LOCATION</b> (City, town, or county) <b>Adair Co. Mo.</b>			(State)			
<b>24. FUNERAL DIRECTOR</b> <b>Davis &amp; Davis Funeral Home</b>					ADDRESS <b>Kirksville, Mo.</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>2-4-1960</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Dora W. Raloff</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

WILLIAM F. BERGEN, D.O.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kirksville, Md.

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.