

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018067

FILED VS. MAY 9 1960 352

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No. 34

ENDED

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|---|---|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Taney | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Crawford | | | | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Forsyth | | Length of stay in 1b 3 years | | c. CITY OR TOWN Pittsburg | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Lakeview Rest Home | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (if outside, give location) unknown | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MAGDALEN BIGERT MUNSON | | | | 4. DATE OF DEATH Month Day Year April 25, 1960 | | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 4-11-69 | 9. AGE (last birthday) 91 | IF UNDER 1 YEAR Months 0 Days 14 | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | | 10b. KIND OF BUSINESS OR INDUSTRY Attorney | | 11. BIRTHPLACE (City and state or country) N.Y. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME unknown | | | 13b. MOTHER'S MAIDEN NAME unknown | | | 14. NAME OF HUSBAND OR WIFE none | | |
| 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. none | | 17. INFORMANT Address H.E. Munson Joplin, Mo | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrostatic Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Acute Bronchitis DUE TO (c) Atherosclerosis, Senility | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 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 | | |
| 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.) | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | 20d. INJURY OCCURRED WHILE AT WORK <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 | | |
| 21. I attended the deceased from 5-24-57 to 4-25-60 and last saw her/him alive on 4-24-60 Death occurred at 4-25-60 12:20P. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Mary King, D.O. | | | | 22b. ADDRESS Forsyth, Mo | | | 22c. DATE SIGNED 4-29-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE 4-25-60 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Hope. | | 23d. LOCATION (City, town, or county) Joplin, Mo | | STATE (State) | | |
| 24. FUNERAL DIRECTOR ADDRESS Whelchel Chapel Branson, Mo | | | 25. DATE RECD. BY LOCAL REG. 5/3/60 | | 26. REGISTRAR'S SIGNATURE Helew Campbell | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.