

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

FILED VS DEC 5 1960

**=60-040888**

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 341

ENDED

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Adair</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>                    |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Kirksville</u>                            |  | c. CITY OR TOWN <u>Kirksville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Kirksville Osteopathic Hosp</u> |  | d. STREET ADDRESS (If outside, give location)<br><u>527 N. Baltimore</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |

|   |                                  |   |  |   |  |  |
|---|----------------------------------|---|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Michael</u> Middle <u>D.</u> Last <u>Bunch</u>                          |                                  |   | 4. DATE OF DEATH<br>Month <u>November</u> Day <u>24</u> Year <u>1960</u> |   |  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4-30-60</u>                                       | 9. AGE (last birthday)<br><u>6 months</u>                             | IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>24</u> Hours <u></u> Min. <u></u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>none</u>              |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>none</u>  |  | 11. BIRTHPLACE (City and state or country)<br><u>Joliet, Illinois</u> |  |  |
| 10c. CITIZEN OF WHAT COUNTRY<br><u>USA</u>  |                                  | 13a. FATHER'S NAME<br><u>Von Bunch</u>  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Barbara (Acton) Bunch</u>             |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>none</u> |                                  | 16. SOCIAL SECURITY NO.<br><u>none</u>  |  | 17. INFORMANT<br><u>Von Bunch</u> Address <u>527 N. Baltimore</u>     |  |  |

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|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Anoxia</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> |  |  |
| DUPLICATE TO (b) <u>Overwhelming Respiratory Infection</u> <u>36 hours</u>   |  |  |
| DUPLICATE TO (c) <u>Laryngo-Tracheo Bronchitis</u> <u>48 hours</u>   |  |  |

|  |  |  |  |
|--|--|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>None</u> |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
|--|--|--|--|

|   |   |  |   |
|---|---|--|---|
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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<br>Hour <u></u> Month, Day, Year <u></u><br>a.m. <u></u> p.m. <u></u>         | 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 November 23, 1960 November 24 and last saw <sup>her</sup>him November 24, 1960  
Death occurred at 7:15 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.

|   |   |                                     |
|---|---|-------------------------------------|
| 22a. SIGNATURE<br><u>Wilson S. King</u> (Degree or title) | 22b. ADDRESS<br><u>Kirksville, Missouri</u> | 22c. DATE SIGNED<br><u>11-25-60</u> |
|---|---|-------------------------------------|

|  |                                       |  |   |
|--|---------------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>November 11, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Fugate Cemetery</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Greentop Missouri</u> |
|--|---------------------------------------|--|---|

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|--|---|---|
| 24. FUNERAL DIRECTOR<br><u>Dee Riley Funeral Home, Inc. Kirksville, Mo.</u><br><u>W. R. Jackson, Pres.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>11-26-60</u> | 26. REGISTRAR'S SIGNATURE<br><u>Doris W. Rath</u> |
|--|---|---|

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NELSON D. KING, 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 or by Larry K. Jackson, Student Embalmer No. 618

working under my personal supervision.

Student Larry K. Jackson  
Signature of Student Embalmer

Signed Wm K. Jackson

Licensed Embalmer No. 3954

P. O. Address Kuberville

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