

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036264

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registered on **FILED OCT 23 1961** Primary Registration District No. **5291** Registrar's No. **107**

AMENDED

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Liberty		Length of stay in lb 5 months	c. CITY OR TOWN Liberty Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION IOOF Hospital		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route #1 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Eva M. Bumgarner			4. DATE OF DEATH Month Day Year Oct. 17 1961
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 1-21-68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Lowder, Illinois	9. AGE (last birthday) 93 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Joseph R. Moffett		13b. MOTHER'S MAIDEN NAME Jennie K. Wilson	14. NAME OF HUSBAND OR WIFE Leaf S. Bumgarner
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 O.R. Bumgarner, Rt. #1, Liberty, 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) Cerebral embolism and infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Cardiac insufficiency			INTERVAL BETWEEN ONSET AND DEATH terminal 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized arteriosclerosis, senility, malnutrition			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 January 1959 to 10-5-61 and last saw her alive on 10-5-61 Death occurred at 11:05 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Wm. R. Morrison, D.D.		22b. ADDRESS 10 West Kansas Liberty, Mo.	22c. DATE SIGNED 10-18-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-20-1961	23c. NAME OF CEMETERY OR CREMATORY Salisbury Cemetery	23d. LOCATION (City, town, or county) (State) Salisbury, Missouri
24. FUNERAL DIRECTOR ADDRESS Pasley Funeral Home, Liberty, Mo.		25. DATE RECD. BY LOCAL REG. 10-18-1961	26. REGISTRAR'S SIGNATURE Mabel Streham

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

NOV 8 1961

MAR 6 1962

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 John Pasley

Licensed Embalmer No. 4308

P. O. Address Shelby, W.V.

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.