No. 2
2-43
12-39
X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4243

FILED FEB 17 1947
Registration District No. ____

Primary Registration District No. 3009

Registrar's No. 7

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Jackson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 815 E. 2nd S. St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cape Gir 16 2
(c) City or town Jackson (If outside city or town limits, write "RURAL")
(d) Street No. 815 E 2nd South St 1
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Clarence E. Mungle
3. (b) If veteran, name war ____
3. (c) Social Security No. ____

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Hattie Alpha Mungle
6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Nov. (Month) 17 (Day) 1888 (Year)

8. AGE: Years 58 | Months 2 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Jackson (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Farming

11. Industry or business ____

MOTHER
12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)

FATHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)

16. (a) Informant James E. Mungle
(b) Address Millersville R. 1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-47 (Month) (Day) (Year)
(c) Place: burial or cremation Jackson city Cemetery

18. (a) Signature of funeral director Frost & Allen
(b) Address Jackson Mo

19. (a) 3-13-47 (Date received local registrar) (b) O. H. Seibert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 2
year 1947 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Shot gun wound through the heart - Self inflicted	
Due to ____	
Due to ____	
Other conditions (Include pregnancy within 3 months of death) ____	
Major findings: Of operations ____	
Of autopsy ____	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Suicide
(b) Date of occurrence Feb. 2 1947
(c) Where did injury occur? Jackson (City or town) Cape (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 815 E. 2nd South St. (Specify type of place)
While at work? No (e) Means of injury Gun shot

23. Signature J. F. Sigmund (M. D. or other) Coroner
Address Jackson Mo Date signed 2/3/47

48 (Licensed Embalmer's Statement on Reverse Side)

[illegible] Health Officer No. 4

District File Number 247-219

Date Filed 2-13-47

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Thos. H. Price

Licensed Embalmer No. 4050

P. O. Address Anderson

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
I—3-45
P1 X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 52 Primary Registration District No. 63009 Registrar's No. 7

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Jackson
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Clarence E. Mungle

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Nov. 17 1884
(Month) (Day) (Year)

8. AGE: Years 58 Months 3 Days 4 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name

13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 3-13-47 (Date received local registrar) (b) D. G. Liebert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 13 day

year 1947 hour minute M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S-4243