S. No. 2
M—2-43
5-17-39
I 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. 4244

FILED FEB 17 1947

Registration District No. ____ Primary Registration District No. 3009 Registrar's No. 6

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

3. (a) PRINT FULL NAME Hattie Alpha Mungle
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Clarence Mungle
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased Feb. (Month) 1 (Day) 1894 (Year)

8. AGE: Years 53 | Months 0 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Whitewater (City, town, or county) MO (State or foreign country)
10. Usual occupation House Wife
11. Industry or business ____
MOTHER FATHER
12. Name John McElreath
13. Birthplace State of Georgia (City, town, or county) (State or foreign country)
14. Maiden name Marabelle Jones
15. Birthplace Mayfield (City, town, or county) Kentucky (State or foreign country)
16. (a) Informant William McElreath
(b) Address Cape Girl. State College Mo
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 Thos. K. Miller
(b) Address Jackson Mo
19. (a) 2-4-47 (Date received local registrar) (b) D. G. Sutter (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 right lung
Due to Being shot by her husband
Due to Clarence E. Mungle
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) Homicide
(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. Second South St. (Specify type of place)
While at work? No (e) Means of injury Shot Gun
23. Signature D. F. Sutter (M. D. or other) Coroner
Address Jackson Mo Date signed 2/3/47

(Licensed Embalmer's Statement on Reverse Side)

[illegible] Health Officer No. 4

[illegible] File Number 247-216

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. E. [illegible]

Licensed Embalmer No. 4053

P. O. Address Hickman

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