LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 781 File No. 36085

or

Village ..... Primary Registration District No. 1003 Registered No. 9450

or

City St Louis Mo (NO Mo Pac Hosp St Louis Mo 14 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME David Dunn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Dec 1 (Month) (Day) 1863 (Year)

7 AGE: 58 yrs. 10 mos. 11 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry business, or establishment in which employed (or employer): Mo Pac R.R.

9 BIRTHPLACE (City or town, State or foreign country): Mississippi

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Clary

(Address) Mo Pac Hosp St Louis Mo

15 Filed OCT 12 1913, 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 11 (Month) (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 10-9, 1918, to 10-11, 1918, that I last saw him alive on 10-11, 1918, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate Gland

SIC

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. J. Clary M. D.

10-11, 1918 (Address) Mo Pac Hosp St Louis Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? Unknown

Former or usual residence 3358 Manhattan Ave St Louis

19 PLACE OF BURIAL OR REMOVAL: St Mathews

DATE OF BURIAL: Oct 14, 1918

20 UNDERTAKER: Clem Heck

ADDRESS: 412 Hunchingsette

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

1 PLACE OF DEATH

County .....

Township ..... or

Village ..... or

City ..... (NO. ..... St. ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word)

6 DATE OF BIRTH ..... (Month) ..... (Day) ..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15
Filed ....., 191..... .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH ..... (Month) ..... (Day) ....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191..... to ....., 191..... that I last saw h..... alive on ....., 191..... and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ..... 191.....

20 UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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