LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

26083

1 PLACE OF DEATH

unty DeKalb

wnship Pleasant

age Queen City

Registration District No. 806 File No.

Primary Registration District No. 4485 Registered No. 10

(No. St. Ward)

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

2 FULL NAME William Henry Dunham

## PERSONAL AND STATISTICAL PARTICULARS

| | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| | W | Married |

TE OF BIRTH May (Month) 6 (Day) 1851 (Year)

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

69 yrs. 2 mos. 9 ds.

CUPATION (Trade, profession, or icular kind of work) Retired

General nature of industry ness or establishment in ch employed (or employer)

THPLACE (City or town, or foreign country) Iowa

10 NAME OF FATHER Dont Know

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

12 MAIDEN NAME OF MOTHER Dont Know

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

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

formant Mrs W. H. Dunham

(Address) Queen City Mo

ed Aug 10, 1920 H. H. Grieber Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 15 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 10, 1920, to July 15, 1920, that I last saw h alive on July 16, 1920, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

1 a Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

July 16 1920 (Address) Queen City Mo

*Give 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 Myers Cemetery DATE OF BURIAL July 17 1920

20 UNDERTAKER E. E. Johnson ADDRESS Queen City Mo

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.

V. S. No. 2. A

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

MARGIN RESERVED FOR BINDING

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**1 PLACE OF DEATH**

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ..... St.; ..... Ward)

(If death occurr hospital or inst give its NAME of street and nu

**MISSOURI STATE BOARD OF HEAL**
**BUREAU OF VITAL STATISTICS**
**CERTIFICATE OF DEATH**

**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), 1..... (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**

....., 191.
(Month) (Day)

**17** I HEREBY CERTIFY, that I attended deceased

.....191....., to....., 19

that I last saw h.....alive on....., 19

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)

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

(Signed) .....

....., 191..... (Address) .....

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

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

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

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

Former or usual residence .....

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 1 |
|---|---|
| 20 UNDERTAKER | ADDRESS |