LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

21937

PLACE OF DEATH
County Macon Registration District No. 532 File No.
Township La Plata Primary Registration District No. 5711 Registered No. [redacted] 17
City (No. St. Ward)
FULL NAME William A Dunnigton
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
h of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
ale	White	Widower

MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Lou Dunnigton

TE OF BIRTH (MONTH, DAY AND YEAR) Jan 3-1857

E	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	66	6	5	

CUPATION OF DECEASED
a) Trade, profession, or articular kind of work Farmer
b) General nature of industry, usiness, or establishment in hich employed (or employer)
c) Name of employer

THPLACE (CITY OR TOWN) Macon Co
STATE OR COUNTRY)
NAME OF FATHER Branson Dunnigton
BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Tennessee
MAIDEN NAME OF MOTHER Mis Dale
BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Missouri
FORMANT Alma C. Dunnington
ddress) La Plata Mo
LED 7-9, 1923 C. H. Buckley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 8 1923.

17.
I HEREBY CERTIFY, That I attended deceased from Aug-24, 1922, to July 8, 1923, that I last saw him alive on July 7, 1923, and that death occurred, on the date stated above, at July 8, 5a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis agitans
8 + 1 B
(duration) 2 yrs. mos. ds.

73

CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? at place of death.
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? none.
(Signed) H. O. Newton, M. D
July 9, 1923 (Address) La Plata Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Steel Cemetary	7/9 1923
20. UNDERTAKER	ADDRESS
D S Christie	La Plata Mo

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

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

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

City..... (No....., ...St. .....W

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....,
that I last saw h..... alive on....., 19.....,
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
20. UNDERTAKER	ADDRESS