

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

Do not use this space.

1411

1. PLACE OF DEATH

County Jackson
Township Law
City J. C. Mo.

Registration District No. 399
Primary Registration District No. 2012
(No. St. Joseph Hosp.)

File No. _____
Registered No. 403
St. _____ Ward) _____

2. FULL NAME

(a) Residence No. 4202 Tracy St. 15 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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Effie Dunham

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

March 29 - 1868

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

61

10

0

8. OCCUPATION OF DECEASED

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

Doctor

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

M. D.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ind.

10. NAME OF FATHER

J. M. Dunham

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ind.

12. MAIDEN NAME OF MOTHER

Elphie Chapman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ind.

14. INFORMANT

(Address)

Mr. W. L. Carrollton Mo.

15. FILED

Jan 28, 1930

M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Jan 27 1930

17.

I HEREBY CERTIFY, That I attended deceased from Jan 10th 1930 to Jan 27th 1930.
That I last saw him alive on Jan 9th 1930, and that death occurred, on the date stated above, at 9th p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

59
73 Diabetes Mellitus

(duration) 7 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY)

Chronic Myocarditis
unknown yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

Unknown

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

Physical & Clinical signs

(Signed)

W. L. Anderson M. D.

1/8 1930 (Address) 200 B. St. City 31st & Prospect

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Memorial Park Jan 29 1930

20. UNDERTAKER

ADDRESS

Rose Anderson City

N. E.—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.

