

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

Do not use this space.

6643

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township *St Louis Mo*

Primary Registration District No. **1003**

City *St Louis Mo* (No. *2819*)

Samble

File No.

Registered No. **1463**

St. Ward)

2. FULL NAME

Dorris Dunn

(a) Residence. No. *2819 Samble* St., *21* Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *5* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *9/9/1928*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
1 5 - - -

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

9. BIRTHPLACE (CITY OR TOWN) *St Louis Mo*
(STATE OR COUNTRY)

10. NAME OF FATHER *Arthur Dunn*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St Louis Mo*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Mable Primm*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Cape Girardeau Mo*
(STATE OR COUNTRY)

14. INFORMANT *Arthur Dunn*
(Address) *2819 Samble St*

15. FILED *May 11 1930*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2/9 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 6 - 1930*, to *Feb 9 1930*, and that I last saw her alive on *Feb 8 1930*, and that death occurred, on the date stated above, at *9:45 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Labar Pneumonia

108 (duration) yrs. mos. *5* ds.

CONTRIBUTORY (SECONDARY) *1011* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

9 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical Symptom*

(Signed) *L. W. Nathall* M. D.

. 19 (Address) *1011 1/2 Jefferson*

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Greenwood Cemetery* DATE OF BURIAL *2/12 1930*

20. UNDERTAKER *Dunn Bros* ADDRESS *215 1/2 Jefferson*

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.

