

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

Do not use this space.

30376

1. PLACE OF DEATH

County New Madrid
Township Cross
City Parma (No. _____)

Registration District No. 606
Primary Registration District No. 4869

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Octavia Nadine Dunkan

(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. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1923-5-28

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
10 10 4 2

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Nil
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

13. NAME Alvyn Dunkan

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME Avis G. Widner

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Alvyn Dunkan (ADDRESS) Parma, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Malden DATE Oct-1-33

19. UNDERTAKER J C Knight (ADDRESS) Parma, Mo

20. FILED Sept 3, 1933 Mrs C. S. Blackway Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 30, 1933

22. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1933, to Sept 30, 1933
I last saw her alive on Sept 30, 1933 Death is said to have occurred on the date stated above, at 6 a.m.

The principal cause of death and related causes of importance were as follows:

Diphtheria
10
36
10
Other contributory causes of importance: Streptococcus faecalis

Date of onset _____

Name of operation _____ Date of _____
What test confirmed diagnosis Clinical Was there an autopsy? 16

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) John Husted, M. D.

(Address) Parma, 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. OCT 20 1933

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

1933
10

1933-9-30

1923-5-28

10-4-2

0
1933-9-30
1923-5-28

6