

LESD APR 12 1939

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

8918
Do not use this space.

1. PLACE OF DEATH

(a) County / Registration District No. **791**
 (b) Township / Primary Registration District No. **1003**
 (c) City **St. Louis** (d) Street No. **Firmin Desolage Hospital** St. **2683**
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. **516 Jessie Dunn** St. **5**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 17-1874**

7. AGE YEARS **64** MONTHS **9** DAYS **4** If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **At home**
 9. Industry or business in which work was done, as 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) **Canton** (STATE OR COUNTRY) **Missouri**

FATHER 13. NAME **J. W. Penn**

14. BIRTHPLACE (CITY OR TOWN) **unknown** (STATE OR COUNTRY) **Virginia**

MOTHER 15. MAIDEN NAME **Susan Alice Groves**

16. BIRTHPLACE (CITY OR TOWN) **Canton** (STATE OR COUNTRY) **Missouri**

17. INFORMANT **A. M. Dunn** (ADDRESS) **6100 Pershing**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Canton, Mo** DATE **March 23, 1939**

19. FUNERAL DIRECTOR (NAME) **C. R. Dutton + Sons** (ADDRESS) **7233 Delmar University City**

20. FILED **MAR 21 1939** **J. F. Bredt** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **3/21**, 19**39**

22. I HEREBY CERTIFY, That I attended deceased from **2/6**, 19**39**, to **3/21**, 19**39**

I last saw her alive on **3/21**, 19**39**. Death is said to have occurred on the date stated above, at **12 noon**. The principal cause of death and related causes of importance were as follows:

1. **Pseudo Myxoma Peritonei**
 2. **Chronic Intestinal Obstruction**
Malignant
 Other contributory causes of importance:
 1. **Pulmonary Edema**
 2. **Myocardial pathology**

Name of operation **Exploratory Lap** Date of **2/8/39**
 What test confirmed diagnosis? **Biopsy** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? **No** 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? **No**
 If so, specify
 (Signed) **Armand C. Forster**, M. D.
 (Address) **1004 Mo. Dealee Bldg.**

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

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Clarence H Murray

Licensed Embalmer No. 4011

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.