

U.S.D JUN 20 1939

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

18327
Do not use this space.

1. PLACE OF DEATH

(a) County Cedar Registration District No. 163
(b) Township Eldorado Spring Primary Registration District No. 4095 Registered No. 36
(c) City Eldorado Spring (d) Street No. _____ St.
(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. 201 S. Forest Eldorado Spring, Mo. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county & city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>William F. Dunaway</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>aug 2 1848</u>		
7. AGE	YEARS <u>90</u>	MONTHS <u>9</u>
	DAY <u>15</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	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) (STATE OR COUNTRY) <u>Christian Co Ky.</u>		
FATHER	13. NAME <u>James Alder</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>va.</u>	
MOTHER	15. MAIDEN NAME <u>Sarah E. Pyle</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>va.</u>	
17. INFORMANT (ADDRESS) <u>Mrs Alice Nippes</u> <u>Eldorado Spring Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>City cern</u> DATE <u>May 18 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Carolyn Hafus</u> <u>200 S. Main Eldorado Spring Mo.</u>		
20. FILED <u>5-17-1939</u> <u>J.W. Dawson</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 16 1939
22. I HEREBY CERTIFY, That I attended deceased from May 6th 1939, to May 16th 1939
I last saw her alive on May 16th 1939. Death is said to have occurred on the date stated above, at 12:42 a.m.
The principal cause of death and related causes of importance were as follows:

Myocarditis

Date of onset

May 12 39

Other contributory causes of importance:

Suppuration of Gall Bladder
Sorelity

Name of operation None Date of _____

What test confirmed diagnosis? Ch. Ray 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 None, 19____

Where did injury occur? None
(Specify city or town, county, and State)

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

Manner of injury None

Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify No

(Signed) J.W. Richardson M. D.

154 (Address) 11. Office Mo

9321

RECEIVED
District Health Officer No. 7,
District File Number 7-29-918
Date Filed 6-6-39

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 Carolyn Nabus

Licensed Embalmer No. 2635

P. O. Address Eldorado Springs

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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PLACE OF DEATH

(a) County Cedar Registration District No. 163
 (b) Township _____ Primary Registration District No. 4075 Registered No. 36
 (c) City Eldorado Springs Street No. _____ St. _____
 (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 Lucy Jane Dunaway

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid (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.
	<u>90</u>	<u>9</u>	<u>15</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 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) (STATE OR COUNTRY) _____

FATHER

13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-16 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Myocarditis
Gall Stones
Infection of gall bladder
Senility

Other contributory cause of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? 930 Was there an autopsy? _____

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) J. W. Richardson, M. D.
 (Address) Stiffin

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. REGISTERED IN RED PENCIL.

Local Registrar.

