

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.

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

44861  
Do not use this space.

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 834

(b) Township Rock Primary Registration District No. 6097

(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_

(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 WILLIAM EDWARD DUNIVAN

(a) Residence, No. Stoddard Court St.  (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 MO. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 3, 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>82</u>	<u>8</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) MD.

FATHER

13. NAME John Dunivan

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

MOTHER

15. MAIDEN NAME unbrum

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) W. L. Dunivan

18. BURIAL, CREMATION, OR REMOVAL PLACE Natione, Leura DATE \_\_\_\_\_

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Watkins  
Depleis mo

20. FILED 1-5 1940 D. S. McJee Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) DEC 18 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 9, 1939, to Dec 9, 1939

I last saw him alive on Dec 9, 1939. Death is said to have occurred on the date stated above, at 1:30 p.

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

CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION

Date of onset ?

Other contributory causes of importance: 121

CHRONIC NEPHRITIS ?

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? none Was there an autopsy? no

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) W. L. Harris M. D.

(Address) Bloomfield, Mo.

61-5-56

RECEIVED

District Health Officer No. 2,

District File Number 140-510

Date Filed 1-9

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.....

*Virgil Welch*

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Virgil Welch*  
.....  
Licensed Embalmer No. 4102

P. O. Address.....

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.