

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
STANDARD CERTIFICATE OF DEATH

State File No. 30222
Registrar's No. 7499

Registration District No. 791 Primary Registration District No. 1003

REC'D
OCT 25 1940

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Infirmary
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution 2yr. 10mo. 1day
(Specify whether
In this community 76 years
years, months or days)

3. (a) PRINT FULL NAME Thomas Dunwoody

3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown Unknown 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Dunwoody

13. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Bridgett Mullins

15. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. J. Sullivan

(b) Address 5800 Arsenal

17. (a) BURIAL (b) Date thereof SEPT. 7, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MOUNT. OLIVE CEMETERY

18. (a) Signature of funeral director Edw. P. Howard & Sons

(b) Address 4219 ST. DENIS AVE.

19. (a) SEP 8 1940 (b) J. J. Sullivan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 13
(If outside city or town limits, write "RURAL") 0
(d) Street No. 5800 Arsenal
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 4
year 1940 hour 12:15 minute _____ A.M.

21. I hereby certify that I attended the deceased from Nov. 3, 1938, to Sept. 4, 1940,
that I last saw him alive on Sept. 4, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Degenerative Heart Disease

Due to arteriosclerosis

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Sec. J. Byrd (M. D. or other) _____

Address _____ Date signed _____

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 jos. A. Howard
Licensed Embalmer No. 4139
P. O. Address 4212 ST Louis

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.