

DEC 18 1940

Registration District No. 250

Primary Registration District No. 5349

State File No. \_\_\_\_\_

Registrar's No. 26

1. PLACE OF DEATH:

(a) County DAVLESS  
(b) City or town RURAL MONROE TOWNSHIP  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days \_\_\_\_\_

3. (a) PRINT FULL NAME AURA LENA DUNNINGTON

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

4. Sex fe 5. Color or race W. 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased NOV. 16 1940  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace GALLATIN B.F.P. MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name THOMAS DUNNINGTON

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

14. Maiden name IDA MIRE FULLWOOD

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

16. (a) Informant THOS. DUNNINGTON

(b) Address GALLATIN MO. R-1

17. (a) BURIAL (b) Date thereof 11/24/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LICK FORK CEM.

18. (a) Signature of funeral director E. M. Hoover

(b) Address Lick Fork, Mo.

19. (a) Nov 23 1940 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County DAVLESS

(c) City or town RURAL  
(If outside city or town limit: write "RURAL")

(d) Street No. B.F.D. # 1  
(If rural, give location)

(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23  
year 1940 hour 9 minute AM

21. I hereby certify that I attended the deceased from Nov 16  
\_\_\_\_\_ 1940, to Nov 24 1940.

that I last saw him alive on Nov 22 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Duration 4 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

23. Signature J. A. Hoover (Specify type of poison) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. A. Hoover (M. D. or other) MD.  
Address Lick Fork, Mo. Date signed Nov 23 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

109K

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**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.....

Licensed Embalmer No.....

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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38584

Registration District No. 250

Primary Registration District No. 5349

Registrar's No. ....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Darwin  
(b) City or town Monroet P.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Aura Lena Dunnington

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 8

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

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

8. AGE: Years Months Days If less than one day  
0 0 7 hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 7 day 23 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia chronical Duration.....  
Due to.....  
Due to.....

Other conditions none 107W  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy.....

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?  
..... (Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

