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State File No.  
Registrar's No. 9

FED JAN 25 1941  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 749 746 Primary Registration District No. 2988 Registrar's No. 9

1. PLACE OF DEATH:  
(a) County Reynolds  
(b) City or town Rural  
(c) Name of hospital or institution: Black River  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community all his life (Specify whether years, months or days) 2

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Reynolds  
(c) City or town Rural Black River  
(If outside city or town limit- write "RURAL")  
(d) Street No.  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME NORMAN DOYLE DUNN  
8. (b) If veteran, name war. (c) Social Security No.  
4. Sex MAKE, race WHITE  
5. Color or race WHITE  
6. (a) Single, widowed, married, divorced  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased: July 12 1940 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 9/14/40 day year hour minute M.  
21. I hereby certify that I attended the deceased from 8/18/40 to 9/14/40, 1940 that I last saw him alive on 9/13/40 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
2 2 hr. min.

Immediate cause of death: Enteric colitis  
Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations  
Of autopsy

9. Birthplace: Black Mo. (City, town, or county) (State or foreign country)  
10. Usual occupation  
11. Industry or business  
12. Name WILLIAM HENRY DUNN  
13. Birthplace Black Mo. (City, town, or county) (State or foreign country)  
14. Maiden name JULIA MOSES  
15. Birthplace Black Mo. (City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant WILLIAM HENRY DUNN  
(b) Address Black Mo.  
17. (a) Black Mo. (b) Date thereof 9-15-40 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation BROWN CEMETERY  
18. (a) Signature of funeral director  
(b) Address  
19. (a) (Date received local registrar) (b) (Registrar's signature)

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 E. M. Pesterich (M. D. or other) 1748  
Address Pesterich Date signed 9/15/40

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

90

RECEIVED

District Health Officer No. 5,

District File Number. 4184

Date Filed \_\_\_\_\_

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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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 403661  
Registrar's No. 9

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 746

Primary Registration District No. 5980

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

1. PLACE OF DEATH:

(a) County Reynolds  
(b) City or town Black River Twp.  
(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 \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME

Norman Doyle Dunn

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

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

8. AGE: Years Months Days If less than one day  
2 2 \_\_\_\_\_ 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)

(Burial, cremation, or removal) \_\_\_\_\_

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) mar 5 1941 (b) ms J J Payne (Date received local registrar) (Registrar's signature)

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.

20. MEDICAL CERTIFICATION

20. DATE OF DEATH Month 9 day 14 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature C J Fitzpatrick (M. D. or other) \_\_\_\_\_

Address Testerville, Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

