

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

I. PLACE OF DEATH:

(a) County Putnam
(b) City or town Unionville, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Monroe Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Hospital - 3 months
(Specify whether
In this community lifetime
years, months or days)

3. (a) PRINT FULL NAME Ida Dunkin

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

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

6. (b) Name of husband or wife Henry J Dunkin 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Jan 25 - 1885
(Month) (Day) (Year)

8. AGE: Years 55 Months 7 Days 6 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Housework

12. Name James H. Skipper
13. Birthplace Do Not Know Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Mary G. Mares
15. Birthplace Do Not Know Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Henry J Dunkin

(b) Address Unionville, Mo

17. (a) Burial (b) Date thereof Feb 3 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woods County

18. (a) Signature of funeral director J. H. Stewart

(b) Address Unionville Mo 64481

19. (a) Feb 4 - 41 (b) N. W. Bellman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Putnam
(c) City or town Rural Lemons, Mo. 0
(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? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 1
year 1941 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from Nov - 21, 1940, to Feb - 1, 1941,
that I last saw her alive on Feb - 1 -, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death: Surgical Shock
amputation - RT. Femur
Due to C.M.R. Bacteriemia
of Right Femur
Due to Fracture - Right
Hip and middle Third Femur
Other conditions: _____
(Include pregnancy within 5 months of death)

Duration
4 hrs
1937
Nov 21
1940

Major findings: Ch. infection
of Bone and 3rd femur to head
of autopsy
no cancer

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?
Farm Home
While at work? No (Specify type of place) (e) Means of injury _____

23. Signature Phil Martin (M. D. or other) 0
Address Unionville Date signed 2/3/41

195 Me
99

RECEIVED

District Health Officer No. 10

District File Number 3-41-484

Date Filed MAR 8 1941

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 James W Comstock

Licensed Embalmer No. 4197

P. O. Address Yonkersville, Mo

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. 7900
Registrar's No. _____

Registration District No. 718

Primary Registration District No. 6430

1. PLACE OF DEATH:

(a) County Putnam
(b) City or town Unionville
(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

Ida Dunkin

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m
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 55 Months 7 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (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)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 1
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 11/21 1941 to 2/1 1944
that I last saw him RR on 2/1 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Surgical shock Duration _____
amputation Rt. femur

Disease: Chc. osteomyelitis of
dist. femur, fract. of hip
Dist. middle third femur

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Chc. infection of
Bone middle 1/3 femur
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) accident

(b) Date of occurrence _____

(c) Where did injury occur? Unionville Putnam Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
ON FARM

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

23. Signature Thos Martin (M. D. or other) _____
Address Unionville Mo. Date signed 2/14/44

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

SUPPLEMENT

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, fact should be so stated above.