

**AUG 8 1941**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

24627

in District No. 89

Primary Registration District No. 3007

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

Registrar's No. 294

1. PLACE OF DEATH:

(a) County Butler  
 (b) City or town Poplar Bluff  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Home Poplar Bluff Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community life time (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Donald Lee Dunning

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced infant

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

7. Birth date of deceased July 23, 1941  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>4</u>	hr. _____ min.

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

10. Usual occupation infant

11. Industry or business self

MOTHER FATHER  
 { 12. Name Unknown  
 { 13. Birthplace Unknown  
 { 14. Maiden name Oza Dunning  
 { 15. Birthplace Butler County, Missouri

16. (a) Informant's own signature Caro Luttrell  
 (b) Address Poplar Bluff, Missouri

17. (a) Burial (b) Date thereof 7/28/41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Hazel Cemetery

18. (a) Signature of funeral director Greer-Croy Funeral Serv.  
 (b) Address Poplar Bluff, Missouri

19. (a) 7/28/41 (b) Kate Lutz  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27  
 year 1941 hour 4:00 minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from 7-23  
1941 to 7-25, 1941  
 that I last saw him alive on 7-25, 1941  
 and that death occurred on the date and hour stated above 7-27 4:00 AM  
Duration

Immediate cause of death  
Premature Birth  
(26-28 weeks gestation)

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

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

Other conditions Probably Hypothermia  
(Include pregnancy within 3 months of death)  
due to prematurity

Major findings: None  
 Of operations \_\_\_\_\_

Of autopsy None

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) None  
 (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. Porter M.D. (M. D. or other) C  
 Address Poplar Bluff Mo Date signed 7-27

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.

RECEIVED

District Health Officer No. 2

District File Number 841-101

Date Filed 8-6-41

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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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 24637  
Registrar's No. 294

Registration District No. 89

Primary Registration District No. 3007

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

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Poplar Bluff  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Poplar Bluff Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Life (Specify whether years, months or days)

In this community Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Donald L. Dunning

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 S

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
				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) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)

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

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

19. (a) 9-17-41 (Date received local registrar) (b) Belle Kinne (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Butler

(c) City or town Poplar Bluff Mo  
(If outside city or town limits write "RURAL")

(d) Street No. Poplar Bluff Mo (If rural, give location)

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

20. DATE OF DEATH Month..... day..... year..... 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.....

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..... (M. D. or other).....  
Address..... Date signed.....

SUPPLEMENTARY

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

