

FILLED NOV 28 1944

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

39094
Do not use this space.

1. PLACE OF DEATH
(a) County Phelps Registration District No. 677
(b) Township Rolla Primary Registration District No. 4403 Registered No. 137 91
(c) City Rolla (d) Street No. _____ St. 2
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds. 0
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME Arthur Melton DUNIVAN

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Grace Dunivan

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 22 1891

7. AGE YEARS 59 MONTHS 9 DAYS 27 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc. Farmer

10. Date deceased last worked at this occupation (month and year) Oct 1940 11. Total time (years) spent in this occupation 25

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known Tenn

13. NAME James Dunivan

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known Tenn

15. MAIDEN NAME Mary Stevens

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known Tenn

17. INFORMANT (ADDRESS) Grace M. Dunivan

18. BURIAL, CREMATION, OR REMOVAL PLACE Wichita Cem DATE 10-21-44

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Smith & Ferguson
Rolla Mo

20. FILED Oct 21 1944 Geo. H. Myers
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-19-41

22. I HEREBY CERTIFY, That I attended deceased from Sept 25th, 1941 to Oct 19, 1941
I last saw him alive on Oct 18, 1941. Death is said to have occurred on the date stated above, at 10:06 P.M.
The principal cause of death and related causes of importance were as follows:
Pyelo-nephritis (acute) Date of onset 10/18/41

Other contributory causes of importance: 1330

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) James M. Shuckler M. D.
(Address) St. James Mo

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.

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. 39894

Registration District No. 677

Primary Registration District No. 4413

Registrar's No. _____

1. PLACE OF DEATH

(a) County Polk

(b) City or town Galva
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas

(c) City or town Bixby - Rural
(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 _____

3. (a) PRINT FULL NAME Arthur M. Runner

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, Day 22, Year 1941, hour _____, minute _____, M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him/her alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

4. Sex M 5. Color 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: Dec. 22, 1888
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>9</u>		<u>hr</u> <u>min.</u>

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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

19. (a) Oct. 21, 1941 (b) Jos. F. Ayers
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-39094