No. 2
-13-40
-17-39
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

8028

State File No.

Registration District No. 834 Primary Registration District No. 6097 Registrar's No. 4

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Bloomfield (Pct 10) Rural
(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
In this community Entire Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stoddard
(c) City or town Bloomfield (Rural)
(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 Georgia Mabel Dunivan

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

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband ~~or wife~~ Leslie Dunivan
6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased Jan (Month) 1 (Day) 1903 (Year)

8. AGE: Years 39 Months Days 24 If less than one day hr. min.

9. Birthplace Mayfield / Kentucky
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

MOTHER FATHER
12. Name Joseph Page
13. Birthplace / Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Frances Pittman
15. Birthplace / Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Leslie Dunivan
(b) Address Bloomfield, Mo. R.1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN 26 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Roland George Cem.
18. (a) Signature of funeral director Watkins Funeral Svc
(b) Address Bloomfield, Mo.
19. (a) 2-17-42 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25th year 1942 hour 6 minute 10 A.M.

21. I hereby certify that I attended the deceased from April 27, 1937, to Jan. 25, 1942, that I last saw him alive on Jan 17, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death Myeloid Leukemia — Duration unknown
Due to
Due to
Other conditions (Include pregnancy within 3 months of death) None
Major findings:
Of operations
Of autopsy No 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 F. O. Brown (M. D. or other) M.D.
Address 1325 S. Grand Date signed 1/30/42

1131 (Licensed Embalmer's Statement on Reverse Side) St. Louis, Mo.

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 B J Brentlinger

Licensed Embalmer No. 4201

P. O. Address Dexter, 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, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8028

Registration District No. 834 Primary Registration District No. 6097 Registrar's No.

1. PLACE OF DEATH:

(a) County: Stoddard

(b) City or town: Rural
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Georgia M Sullivan

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: M

6. (b) Name of husband or wife

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

7. Birth date of deceased: Jan (Month) 1 (Day) 1903 (Year)

8. AGE: Years 39 Months — Days — 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) (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) Jul 17th 1942 (Date received local registrar) (b) M. R. Thrower (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 25 year 1942 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 — Duration

Due to

Due to

Other conditions
(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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (c) Means of injury

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

SUPPLEMENTARY