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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10881

Registration District No. 212

Primary Registration District No. 5779

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Miller  
(b) City or town Eldon Rural Franklin  
(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 Estelle Addie Dunham

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, widowed 2

6. (b) Name of husband or wife Arthur L. Dunham  
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct. 2 1865  
(Month) (Day) (Year)

8. AGE: Years 77 Months 5 Days 18  
If less than one day hr. min.

9. Birthplace QUINCY Ill. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Ed HARRIS

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

14. Maiden name CATHERINE SPREEN

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

16. (a) Informant A. E. Dunham

(b) Address Eldon, Mo.

17. (a) REMOVAL (b) Date thereof 3-22-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ATCHISON, KANS.

18. (a) Signature of funeral director Phillips Funeral Home

(b) Address Eldon, Mo.

19. (a) 3-22-43 (b) W. S. Speer  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County MILLER 66

(c) City or town Eldon "RURAL" 0  
(If outside city or town limits, write "RURAL")

(d) Street No. FRANKLIN Township  
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 20  
year 1943 hour 10 minute P.M.

21. I hereby certify that I attended the deceased from 7-15  
1943 to 7-20 1943

that I last saw her alive on 3-16 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure  
Duration

Due to senility

Due to nephritis

Other conditions None

(Include pregnancy within 3 months of death)

Major findings: None

Of operations None

Of autopsy No

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 of Blackstreet M.D. or other

Address ELDON MO Date signed 3-21-43

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

1114

RECEIVED

Miller County Health Dep't.

County File Number 43-29

Date Filed 4-6-43

**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.....

Louis D Phillips....., Registered Apprentice No.....  
working under my personal supervision.

Signed Louis D Phillips  
Licensed Embalmer No. 5663  
P. O. Address Bellevue

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10881  
Registrar's No. 21

Registration District No. 212

Primary Registration District No. 2779

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

1. PLACE OF DEATH:  
(a) County Miller  
(b) City or town Rural  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Estelle Addie Dunham  
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 W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased out 2  
(Month) (Day) (Year)

8. AGE: Years 77 Months 2 Days 1 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 \_\_\_\_\_ (State or foreign country)  
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 March day \_\_\_\_\_  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure Duration \_\_\_\_\_

Due to senility  
Due to nephritis acute

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)  
(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 A.F. Burksteiner M. D. or other \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

S-10881