

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 6 1944

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STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5055

Registration District No.

Primary Registration District No.

1003

Registrar's No.

1945

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Baptist Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Four Months
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT

FULL NAME Katherine Dunham

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex Female / 5. Color or race White 6. (a) Single, widowed, married, Widowed
6. (b) Name of husband Stant Dunham 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased 1 - 24 - 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 1 1 _____ hr. _____ min.

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

10. Usual occupation None - Old Age Pensioner

11. Industry or business _____

12. Name Ely Younce

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

14. Maiden name Susie Rohr

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

16. (a) Informant Stella Powell

(b) Address 5735 Etzel

17. (a) Burial (b) Date thereof 2-28-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laurel Hill Cemetery

18. (a) Signature of funeral director Truth Center Mortuary

(b) Address 4024 Lindell Boulevard

19. (a) FEB 20 (b) J. J. Brudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 942A Goodfellow
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 25th
year 1944 hour 6:00 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from _____
to _____, 19____, to _____, 19____.
that I last saw her alive on Feb 24, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Primary cause of death
Primary cause of death
Duration _____

Due to Primary cause of death
Due to _____

Other conditions In hospital at night, kidney,
(Include agency within months of death)
Diabetes, 3 months before death
Major findings Diabetes, kidney, heart
Cooperations None
Of autopsy Yes and also cremation
of cerebellum

Underline the cause to which death was 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 J. J. Brudick (M. D. or other) _____
Address 1310 1/2 N. 13th St. Date signed 3/26/44

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

W E Morris

Licensed Embalmer No. *3360*

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.