No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 20 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30942

Registration District No. 200 — Primary Registration District No. 5725 — Registrar's No. 91

1. PLACE OF DEATH:

(a) County MACON
(b) City or town MACON R.F.D. 11 RURAL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STILL-HILDRETH OSTEOPATHIC SAN.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 41
(c) City or town Bethany 1
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WILLIAM A. DUNHAM
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 Oct (Month) 24 (Day) 1872 (Year)
8. AGE: 72 Years | Months 9 | Days 19 | If less than one day hr. min.
9. Birthplace Harrison City (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name William O Dunham
13. Birthplace Ohio (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Nancy Burton
15. Birthplace Harrison City (City, town, or county) Mo (State or foreign country)

16. (a) Informant Mrs Geo Joyce
(b) Address Bethany Mo
17. (a) removal (Burial, cremation, or removal) (b) Date thereof Aug 13-45 (Month) (Day) (Year)
(c) Place: burial or cremation Bethany Mo
18. (a) Signature of funeral director Aubrey Skinner
(b) Address Macon Mo
19. (a) 9/4/45 (Date received local registrar) (b) Jora B. Hunkler (Registrar's signature)

1037

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13
year 1945 hour 2 minute 05 A.M.

21. I hereby certify that I attended the deceased from August 8, 1945, to August 13, 1945, that I last saw her alive on August 13, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Arterio Sclerotic Kidneys	Indefinite
Due to: Acute Nephritis	
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)
(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 Philip G. Pendergast M.D. (M.D. or other)
Address Macon, Mo Date signed 8/13/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 9-45-1435
Date Filed SEP-1-7-1945

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 Albert Skinner

Licensed Embalmer No. 75-1

P. O. Address Macon 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.