U. S. No. 2
00M—2-43
Rev. 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 APR 1 1947

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

9028

State File No.

Registrar's No. 1272

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
2611 Cypress
(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: 24 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No.: 2611 Cypress 8
(If rural, give location)

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

3. (a) PRINT FULL NAME: JOHN FRANK DUNN

3. (b) If veteran, name war: none

3. (c) Social Security No. 486-05-7308

4. Sex: male 0

5. Color or race: white

6. (a) Single, widowed, married, divorced: married 1

6. (b) Name of husband or wife: Nora

6. (c) Age of husband or wife if alive: 59 years

7. Birth date of deceased: March 19 (Month) (Day) 1890 (Year)

8. AGE: Years 56 Months 11 Days ~~30~~ 29 If less than one day hr. min.

9. Birthplace: Sedalia (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation: Shoeman

11. Industry or business: Public Service Co.

FATHER
12. Name: Lemuel Dunn
13. Birthplace: Otterville (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name: Susan Ruble
15. Birthplace: (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant: Mrs. Nora Dunn
(b) Address: 2611 Cypress

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 3-21-1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Crown Hill, Sedalia, Mo.

18. (a) Signature of funeral director: C. H. Blackman & Son, Inc.
(b) Address: 2825 Independence Blvd.

19. (a) 3-19-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18 year 1947 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from Feb 19, 1947 to March 18, 1947 that I last saw him alive on March 18, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Mitral Insufficiency	
Due to Lobar Pneumonia	1 week
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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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? 0
While at work? (Specify type of place) (e) Means of injury

23. Signature: Carl [illegible] (M. D. or other) MD
Address: 3-19-1947 1103 [illegible] Date signed

(Licensed Embalmer's Statement on Reverse Side)

Dr. Earl Jackson
1103 E. Armour
We 4193

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 O. K. McFarland

Licensed Embalmer No. 4397

P. O. Address Kansas City 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.