

FILED SEP 8 1947

Registration District No. 317

Primary Registration District No. 60763070

Registrar's No. 1873

7-3-47  
7-3-10-5-29  
967

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

1. PLACE OF DEATH:

(a) County.....  
 (b) City or town..... St Louis County  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Glenwood Sanitarium  
 (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 Minnie Dunn  
 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 Widowed  
 6. (b) Name of husband or wife Edwin 6. (c) Age of husband or wife if  
 alive..... years  
 7. Birth date of deceased..... January 30 1883  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
64 7 1 .....hr. ....min.

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

10. Usual occupation..... Nurse

11. Industry or business.....

12. Name John Bryant  
 13. Birthplace..... Tennessee  
 (City, town, or county) (State or foreign country)

14. Maiden name..... Beulah Jewell  
 15. Birthplace..... Tennessee  
 (City, town, or county) (State or foreign country)

16. (a) Informant..... Beatrice Dunn  
 (b) Address..... 5500 Heege Rd Rear

17. (a) Burial (b) Date thereof..... 9/3/47  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation..... New St Marcus Cemetery

18. (a) Signature of funeral director.....  
 (b) Address..... 1926 Allen Av

19. (a) 9-2-47 (b) Carl A. Shaffner  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County.....  
 (c) City or town..... Gardenville  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5500 Heege Rd Rear  
 (If rural, give location)  
 (e) Citizen of foreign country?..... NO (Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August Day 31  
 year..... 1947 hour..... minute..... M.  
 21. I hereby certify that I attended the deceased from....., 19....., 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.....  
Cause unknown  
 Due to.....  
2002  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations.....  
 Of autopsy.....

Duration  
 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 case)  
 While at work?..... (a) Nature of injury.....  
 23. Signature..... Carl A. Shaffner (M. D. 363056)  
 Address..... Commissioner of Health Date signed..... 9-2-47

DEC 16 1947

SEP 8 1947

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 me

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Benny J. Duncan

Licensed Embalmer No. 2272

P. O. Address 1926 Allen Ave

**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.**