No. 300
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 318 1948

Registration District No.

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

1005

Primary Registration District No.

State File No. 27661

Registrar's No. 7716

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Infirmary Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Two days
In this community at Infirmary Hospital (specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 510

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4030 Folsom 9
(If rural, give location) 0

(e) Citizen of foreign country? 18 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Ferman Dunlap

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Linda Dunlap

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased June (Month) 9 (Day) 1884 (Year)

8. AGE: Years 64 | Months 2 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Dent Co. (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Retired

11. Industry or business Restaurant Owner

FATHER
12. Name Unknown 9
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant Linda Dunlap
(b) Address 4030 Folsom Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-48 (Month) (Day) (Year)
(c) Place: burial or cremation Jadwin, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) SEP 1 1948 (Date received by local registrar) (b) J. F. Braeuer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 31
year 1948 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from May 1, 1948 to Aug. 31, 1948;
that I last saw him alive on Aug. 31, 1948;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congestive Heart Failure	48 hrs
Due to: Hypertension and Arteriosclerotic Heart Disease	
Due to: Generalized Arteriosclerosis	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 9 20 0 9 28
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 Mayo Arnold M.D. (M. D. or other)
Address 5600 Arsenal Date signed 8/31/48

(Licensed Embalmer's Statement on Reverse Side)

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 Elmo R. Sadwell

Licensed Embalmer No. 4077

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.