

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

38058
9883

FILED NOV 21 1948

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. LOUIS CITY HOSPITAL MAX C. STARKLOFF MEMORIAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether
In this community _____ years, months or days)

3. (a) PRINT

FULL NAME WILLIAM DUNHAM

3. (b) If veteran,

name war No

3. (c) Social Security No.

None

4. Sex Male

D

5. Color or

race White

6. (a) Single, widowed, married,

divorced married

6. (b) Name of husband or wife Margaret

6. (c) Age of husband or wife if

Little 12/23/07

alive 70 years

7. Birth date of deceased 7/9/69

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

78

4

5

hr.

min.

9. Birthplace Rockingham, Vt.

(City, town, or county)

(State or foreign country)

10. Usual occupation Retired Hotel Proprietor

11. Industry or business Hotel

12. Name Daniel Dunham

13. Birthplace ?

(City, town, or county)

(State or foreign country)

14. Maiden name Isabelle McKay

15. Birthplace Nova Scotia

(City, town, or county)

(State or foreign country)

16. (a) Informant Margaret Dunham

(b) Address Bethlehem, N. H.

17. (c) Removal

(Burial, cremation, or removal)

(b) Date thereof 11/16/48

(Month) (Day) (Year)

(c) Place: burial or cremation Bethlehem, N. H.

18. (a) Signature of funeral director Robert J. Ambruster, Inc.

(b) Address Clayton Rd at Concordia Lane

19. (a) NOV 15 1948

(Date received local registrar)

(b) J. B. Pasater

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State New Hampshire (b) County 999
(c) City or town Bethlehem 27
(If outside city or town limits, write "RURAL")
(d) Street No. Main St 2
(If rural, give location)
(e) Citizen of foreign country? NR. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 14
year 1948 hour 7 minute 45 A.M.

21. I hereby certify that I attended the deceased from 10-31-48
19____, to 11-14-48, 19____

that I last saw him alive on 11-14-48
and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRO VASCULAR
THROMBOSIS

Duration

Due to

Due to

Other conditions DIABETES MELLITUS
(Include pregnancy within 3 months of death)

BRONCHOPNEUMONIA

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? _____

While at work? _____

(Specify type of place)

(e) Means of injury 0

23. Signature Thos. J. Bryan M.D. (M.D. or other)

Address 1515 LAFAYETTE

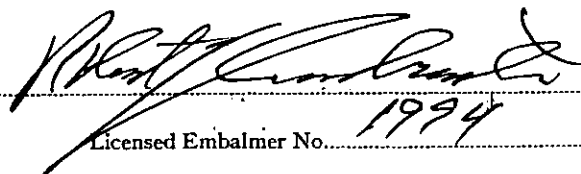
Date signed 11-14-48

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.....



Licensed Embalmer No.....

1994

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.