No. 300
—10-47
5-17-39
I 3906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 24 1948
Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 38058
Registrar's No. 9883

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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME William Dunham

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 1

5. Color or race White

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

6. (b) Name of husband or wife Margaret Little 12/23/07

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased 7/9/69 (Month) (Day) (Year)

8. AGE: Years 78 | Months 4 | Days 5 | If less than one day 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

FATHER
12. Name Daniel Dunham
13. Birthplace ? (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Isabelle McKay
15. Birthplace Nova Scotia (City, town, or county) (State or foreign country)

16. (a) Informant Margaret Dunham
(b) Address Bethleham, N. H.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/16/48 (Month) (Day) (Year)
(c) Place: burial or cremation Bethleham, 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 Lasater (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Nov day 14th
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, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death CEREBRO VASCULAR THROMBOSIS	
Due to	
Due to	
Other conditions DIABETES MELLITUS (Include pregnancy within 3 months of death)	
BRONCHO PNEUMONIA	

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 0

23. Signature Thos L Bryan M.D. (M. D. or other)
Address 1515 LAFAYETTE Date signed 11-14-48

(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.....

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.