

S. No. 2
DM-5-43
v. 5-17-43
I X36671

FILED DEC 29 1948

Registration District No. 149

Primary Registration District No. 1002

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

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:
Roanoke Nursery Home 3660 Summit
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks 4
(Specify whether years, months or days)

In this community 3 weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Oskaloosa

(c) City or town Oskaloosa
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

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

3. (a) PRINT FULL NAME May Boyd Dunn

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Fe

5. Color or race white

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

6. (b) Name of husband or wife Ivan M. Dunn

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased April 6 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>8</u>	<u>2</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name James Wilson

13. Birthplace Dennison Kansas
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Kurs

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Ivan Wilson

(b) Address 4614 Terrace Kansas City, Mo.

17. (a) Removal (b) Date thereof Dec. 8, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oskaloosa, Kans.

18. (a) Signature of funeral director P. H. Heelton

(b) Address 1319 North 18th

19. (a) 12-9-48 (b) Sheldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 8
year 48 hour _____ minute 1 P.M.

21. I hereby certify that I attended the deceased from Dec 1 1948 to Dec 8 1948
that I last saw him alive on Dec 8 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to Hypertension

Due to Paralysis

Other conditions Senility
(Include pregnancy within 3 months of death)

Major findings:
Of operations no

Of autopsy no

Duration

5 yrs

10 yrs

1 yr

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? _____

M. B. Casebolt (Specify type of place)
While at work? _____ (e) Means of injury: _____

23. Signature M. B. Casebolt
Address 4200 Baltimore K.C. Mo.

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

M. Swisher

Licensed Embalmer No.

3505

P. O. Address

Ke Kowas

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.