

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. 7389

No. 300
10.48

FILED APR 8 1949

1024

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 87

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hatton</u>	
c. LENGTH OF STAY (in this place) <u>26 Days</u>		d. STREET ADDRESS (If rural, give location) <u>Rural Route</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Noyes Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>LOD</u> c. (Last) <u>DUNN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 1, 1949</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 31, 1873</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Lincoln County, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Mason Dunn</u>	13b. MOTHER'S MAIDEN NAME <u>Julia Knox</u>	14. NAME OF HUSBAND OR WIFE <u>Agnes Craig Dunn</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. J. Lon Dunn, Hatton, Mo.</u>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>5 years</u> <u>5 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis</u>		
	ANTECEDENT CAUSES <u>with left hemiplegia</u> <u>arteriosclerosis</u> <u>and</u> <u>hypertension</u>		
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)	
		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4500</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from March 7, 1949 to April 1, 1949 that I last saw the deceased alive on April 1, 1949, and that death occurred at 12:10 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>James H. Allen M.D.</u>	(Degree or title)	23b. ADDRESS <u>Columbia, Mo.</u>	23c. DATE SIGNED <u>4-2-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>April 3, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	24d. LOCATION (City; town, or county) (State) <u>Columbia, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>April 2 1949</u>	REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	31	25. FUNERAL DIRECTOR'S SIGNATURE <u>Parson Funeral Service, Columbia Mo.</u>	ADDRESS
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WRITE PLAINLY—USING UNFADING, BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
DISTRICT HEALTH OFFICER NO. 9,
DISTRICT OF COLUMBIA
Date Filed APR 7 1949

SEP 7 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____
Student Embalmer

Signed _____

Licensed Embalmer No. _____

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.