

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 27 1949

State File No. 27999

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 7270

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Pope	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Golconda	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS n.r.	
3. NAME OF DECEASED a. (First) Robert b. (Middle) Hayse c. (Last) Dunning		4. DATE OF DEATH (Month) (Day) (Year) Aug 20 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH March 1, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Unknown, Kansas
13a. FATHER'S NAME James Dunning		13b. MOTHER'S MAIDEN NAME Mollie Wells	14. NAME OF HUSBAND OR WIFE Cora Dunning
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS L. Kellems, 5664 Arsenal St.
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion  ANTECEDENT CAUSES Morbid 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 26, 1949, to Aug. 20, 1949, that I last saw the deceased alive on Aug 20, 1949, and that death occurred at 8:10 P.M., from the causes and on the date stated above.			
23a. SIGNATURE Frank F. Bradley M.D.		23b. ADDRESS Barnes Hospital	
23c. DATE SIGNED 8-20-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 8-21-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Golconda, Ill.
DATE REC'D BY LOCAL REG. AUG 21 1949		REGISTRAR'S SIGNATURE Albert H. Hoppe	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS 4700 Washington Blvd.	

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

**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.

Student .....  
Student Embalmer

Signed Clara P. Padwell

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.