

FILED SEP 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31721
Registrar's No. 8001

REG. DIST. NO. 818

PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE St. Louis, Mo. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3870 Fairview Ave., Mo.		d. STREET ADDRESS (If rural, give location) 3870 Fairview Ave. Mo.	
3. NAME OF DECEASED a. (First) Laura L. Dunham b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Sept. 7 13th 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 7th 1862
9. AGE (In years last birthday) 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Penn.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Horace LaBar		13b. MOTHER'S MAIDEN NAME Lydia Borman	14. NAME OF HUSBAND OR WIFE Louis F. Dunham
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 Lydia M. Dunham 3870 Fairview Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Uteri with Antecedent Causes Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General Abdominal Carcinoma DUE TO (c) Dementia			INTERVAL BETWEEN ONSET AND DEATH 3
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arterio Sclerosis, Cardiac Insufficiency, etc.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) HX Mo.	
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? 172X	
22. I hereby certify that I attended the deceased from 9/10 1949, to 9/13 1949, that I last saw the deceased alive on 9/11 1949, and that death occurred at 7:00 a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Harvey Oct. M.D.		23b. ADDRESS 2810 Sutton	23c. DATE SIGNED 9/14/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/16/49	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. SEP 15 1949	REGISTRAR'S SIGNATURE J.B. Lester	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kraeger-Voss, Inc. 3402 N. Kingshigh way	

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

Harvey Oct. M.D.

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~~ me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Gay W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St Louis Mo

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.