

38670

FILED NOV 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

9808

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) LIFE	
d. FULL NAME OF HOSPITAL OR INSTITUTION. St. Anthony Hospital		d. STREET ADDRESS (If rural, give location) 18 4232 Swan Avenue	
3. NAME OF DECEASED (Type or Print) a. (First) Baby Twin #1 b. (Middle) c. (Last) DUNN		4. DATE OF DEATH (Month) (Day) (Year) Nov - 7 - 49	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED? (Specify) S	8. DATE OF BIRTH Nov-7-49
9. AGE (In years last birthday) 3 IF UNDER 1 YEAR Months 06 IF UNDER 2 HRS. Hours 06 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis Missouri	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Lester Dunn	
13b. MOTHER'S MAIDEN NAME Leenetta Grubbs		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Lester Dunn		ADDRESS 4232 Swan Ave	
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) Pre. Malaria 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 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) St. Louis Missouri	
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? 776X		22. I hereby certify that I attended the deceased from Nov 7, 1949 to Nov 24, 1949 , and that death occurred at 3:15 p.m. , from the causes and on the date stated above.	
23a. SIGNATURE H. J. Moore		23b. ADDRESS 912 50th St	
23c. DATE SIGNED 11/12/49		24a. LOCATION (City, town, or county) (State) St. Louis County Missouri	
24b. DATE 11-8-49		24c. NAME OF CEMETERY OR CREMATORY Mount Hope	
24d. LOCATION (City, town, or county) (State) St. Louis County Missouri		25. FUNERAL DIRECTOR'S SIGNATURE H. W. McLaughlin	
DATE REC'D BY LOCAL REG. NOV 14 1949		ADDRESS 2501 Lafayette Ave	

(Licensed Embalmer's Statement on Reverse Side)

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

8086

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 C. W. Casper

Licensed Embalmer No. 3830

P. O. Address 2301 Lafayette

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.