

No. 300  
10. 45

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15284**

**MAY 2 - 1952**  
BIRTH NO. **82931** REG. DIST. NO. **833** PRIMARY REG. DIST. NO. **3074** Registrar's No. **81**

1003  
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>SCOTT</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>MO</b> b. COUNTY <b>STODARD</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sikeston</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>RURAL - Essex</b>                                     |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>enroute to Mo Delta Comm</b>                      |  | d. STREET ADDRESS (If rural, give location) <b>ESSEX MO RFD #1</b>  |  |

|  |                               |  |  |   |                      |   |
|--|-------------------------------|--|--|---|----------------------|---|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <b>LINDA</b> b. (Middle) <b>KAREN</b> c. (Last) <b>DUNNING</b> |                               |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>3-26-52</b> |   |                      |   |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b> | 8. DATE OF BIRTH <b>NOV 26, 1951</b>                 | 9. AGE (In years last birthday) <b>4</b>                    | IF UNDER 1 YEAR Days | IF UNDER 24 HRS. Hours Min.             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BABY</b>          |                               | 10b. KIND OF BUSINESS OR INDUSTRY                                    |  | 11. BIRTHPLACE (State or foreign country) <b>ADVANCE MO</b> |                      | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 13a. FATHER'S NAME <b>JAMES ARTHUR DUNNING</b>   |  | 13b. MOTHER'S MAIDEN NAME <b>ERNESTINE CASON</b> |  | 14. NAME OF HUSBAND OR WIFE  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO. <b>-</b>                 |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>JAMES A DUNNING Essex Mo. 181</b> |  |

|  |  |  |  |  |  |                                  |  |
|--|--|--|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION                                  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pneumococic Meningitis</b>   |  | ANTECEDENT CAUSES<br>DUE TO (b) <b>Lobar Pneumonia</b> |  |  |  |                                  |  |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. |  | DUE TO (c)   |  |  |  |                                  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.            |  |  |  |  |  |                                  |  |

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION                             |  | 19b. MAJOR FINDINGS OF OPERATION <b>490X</b>   |  |   |  | 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) |  |  |  |
| 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 **3-25**, 1952, to **3-26**, 1952, that I last saw the deceased alive on **3-26**, 1952, and that death occurred at **p m.**, from the causes and on the date stated above.

|   |  |                                     |  |  |  |  |  |
|---|--|-------------------------------------|--|--|--|--|--|
| 23a. SIGNATURE (Degree or title) <b>Gordon C. Henshill D.D.</b> |  | 23b. ADDRESS <b>Bloomfield, Mo.</b> |  | 23c. DATE SIGNED <b>4-2-52</b>                     |  |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>         |  | 24b. DATE <b>3-24-52</b>            |  | 24c. NAME OF CEMETERY OR CREMATORY <b>MATTHEWS</b> |  | 24d. LOCATION (City, town, or county) (State) <b>MATTHEWS MO</b> |  |

|   |  |  |  |     |  |  |  |
|---|--|--|--|-----|--|--|--|
| DATE REC'D BY LOCAL REG. <b>4-24-52</b> |  | REGISTRAR'S SIGNATURE <b>Mrs Ella Hunter</b> |  | 439 |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wells Funeral Home Sikeston Mo</b> |  |
|---|--|--|--|-----|--|--|--|

RECEIVED APR 28 1952

SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 452-121

**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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed Raymond Crews

Signed.....  
Student Embalmer

Licensed Embalmer No. 3467

P. O. Address Leicester 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.