

FILED SEP 27 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29839

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1005</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>DeKalb</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>8 days</u>		c. CITY OR TOWN <u>Maysville</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #2</u>				e. STREET ADDRESS (If rural, give location) <u>0220</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSEPH</u>		b. (Middle) <u>ROBERT</u>		c. (Last) <u>DUNHAM</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 16, 1954</u>	
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>Jan. 1, 1873</u>	
9. AGE (In years last birthday) <u>81</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>DeKalb County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Barton S. Dunham</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Daniels</u>		14. NAME OF HUSBAND OR WIFE <u>Nora B. Dunham</u>			
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 ADDRESS <u>Nora B. Dunham, Maysville, Mo.</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senile Psychosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION  <u>4221</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>1</u>		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. <u>1</u>		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 <u>Sept 8, 19 54</u> , to <u>Sept 16, 19 54</u> , that I last saw the deceased alive on <u>Sept 15, 19 54</u> , and that death occurred at <u>7:20A m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Forrest Thomas M.D.</u>				23b. ADDRESS <u>State Hospital #2, City</u>		23c. DATE SIGNED <u>9-16-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Sept 16, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Maysville Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Maysville, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Sept 20, 1954</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>		FEDERAL DIRECTOR'S SIGNATURE ADDRESS <u>John H. Thomas, Maysville</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 <sup>will be</sup> ~~was~~ embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *[Signature]*.....

Licensed Embalmer No. 396

P. O. address *[Signature]*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.