

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **39643**

FILED NOV 22 1954

BIRTH NO. _____ REG. DIST. NO. **517** PRIMARY REG. DIST. NO. **590** Registrar's No. **2481**

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Berkley City		c. LENGTH OF STAY (In this place) 1 mo.	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION: Penn Nursing Home		e. STREET ADDRESS (If rural, give location) 5255 Potomac	

3. NAME OF DECEASED a. (First) Robert (Type or Print)	b. (Middle) J.	c. (Last) Dunlap	4. DATE OF DEATH (Month) (Day) (Year) Oct. 24, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 17, 1900	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	10b. KIND OF BUSINESS OR INDUSTRY Unavailable	11. BIRTHPLACE (City and State or Foreign Country) Crawford Co., Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Doss Dunlap	13b. MOTHER'S MAIDEN NAME Lulie Eaton	14. NAME OF HUSBAND OR WIFE Unavailable
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Catherine Rucker, 5255 Potomac
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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) Cerebral thrombosis ANTECEDENT CAUSES DUE TO (b) Hypertensive Cardiac-vascular disease DUE TO (c) Previous left hemiplegia	INTERVAL BETWEEN ONSET AND DEATH 3 weeks Unknown
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18a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 443X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)	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 Sept 28, 1954, to Oct 24, 1954, that I last saw the deceased alive on Oct 20, 1954, and that death occurred at 1:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Lewis Lillmann M.D.	23b. ADDRESS 8231 Clayton Rd (17)	23c. DATE SIGNED 10/25/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-25-54	24c. NAME OF CEMETERY OR CREMATORY Eaton Cemetery	24d. LOCATION (City, town, or county) (State) Steeleville, Mo.
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DATE REC'D BY LOCAL REG. 10/25/54	REGISTRAR'S SIGNATURE Robert H. Hoppe	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.
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(Licensed Embalmer's Statement on Reverse Side)

1955 FEB 3 8 833

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.....
Signature of Student Embalmer

Signed *J Wm Binkley*.....

Licensed Embalmer No. *3657*

P. O. Address *St. Louis 8*

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.