

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024623

STATE FILE NUMBER

762

FILED JUL 28 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No.

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| 1. PLACE OF DEATH<br>a. COUNTY Buchanan  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY DeKalb |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Joseph                    |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN Clarksdale 3200                          |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION Mo. Methodist Hosp. |  | Length of stay in lb<br>1 Da  | d. STREET ADDRESS (If outside, give location)<br>RFD # 1 |
| Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |  |   |  |

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|--|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>EVA GRACE DUNLAP |  |  | 4. DATE OF DEATH<br>Month Day Year<br>July 17, 1958 |  |  |
|--|--|--|---|--|--|

|                  |                           |   |                                  |                                       |                              |                                |
|------------------|---------------------------|---|----------------------------------|---------------------------------------|------------------------------|--------------------------------|
| 5. SEX<br>Female | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Feb. 5, 1916 | 9. AGE (In years last birthday)<br>42 | FUNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min. |
|------------------|---------------------------|---|----------------------------------|---------------------------------------|------------------------------|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife | 10b. KIND OF BUSINESS OR INDUSTRY<br>At Home | 11. BIRTHPLACE (City and state or country)<br>St. Joseph, Mo. | 12. CITIZEN OF WHAT COUNTRY?<br>USA |
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|---------------------------------------|---|---|
| 13a. FATHER'S NAME<br>Oliver C. White | 13b. MOTHER'S MAIDEN NAME<br>Wealthy Burton | 14. NAME OF HUSBAND OR WIFE<br>Homer Dunlap |
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|   |                                 |   |         |
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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)<br>No | 16. SOCIAL SECURITY NO.<br>None | 17. INFORMANT<br>Homer Dunlap R 1 Clarksdale, Mo. | Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary Embolism of amniotic fluid |   | INTERVAL BETWEEN ONSET AND DEATH<br>5 min.  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) Pregnancy - full term; membranes ruptured just preceding the embolism. |   |
|   | DUE TO (c) In final stage of labor  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                                     |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m. | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
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| 21. I attended the deceased from Death occurred at | July 16, 1958, to July 17, 1958 and last saw her alive on July 16, 1958 | at 1:00 a. m. on the date stated above; and to the best of my knowledge from the causes stated. |
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|                                  |                                 |                             |
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| 22a. SIGNATURE<br>Dr. Grant M.D. | 22b. ADDRESS<br>St. Joseph, Mo. | 22c. DATE SIGNED<br>7.19.58 |
|----------------------------------|---------------------------------|-----------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial | 23b. DATE<br>Jul. 21, 1958 | 23c. NAME OF CEMETERY OR CREMATORY<br>Ashland Cemetery | 23d. LOCATION (City, town, or county) (State)<br>St. Joseph, Mo. |
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| 24. FUNERAL DIRECTOR<br>Herman W. Sidenfaden | ADDRESS<br>St. Joseph, Mo. | 25. DATE RECD. BY LOCAL REG.<br>July 21, 1958 | 26. REGISTRAR'S SIGNATURE<br>Mrs. Clark Goodell |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *Robert H. Apple* .....

Licensed Embalmer No. 3308 .....  
P. O. Address St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.