

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033933

STATE FILE NUMBER

FILED SEP 23 1958 Registration District No. 316 Primary Registration District No. 6073 Registrar's No. 349

300
1-57

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre -rural		c. CITY OR TOWN Corning	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Perry Twp.		d. STREET ADDRESS (If outside, give location) Rt-1	

3. NAME OF DECEASED (Type or print) First Middle Last CLIFFORD OTTO DUNN			4. DATE OF DEATH Month Day Year August 21, 1958		
---	--	--	--	--	--

5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1906	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months Days 9 19	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	---	--	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Moark, Ark.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	---	--	---

13a. FATHER'S NAME War Dunn	13b. MOTHER'S MAIDEN NAME Addie Carlew	14. NAME OF HUSBAND OR WIFE Minnie I. Dunn
---------------------------------------	--	--

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. 430-26-9828	17. INFORMANT Gene Johnson	Address Riggers, Ark.
--	---	--------------------------------------	---------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broken neck, Broken left leg		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) 4 m multiple injuries		
DUE TO (c) Coronal Fracture of skull; white branching, south, in the center of base of skull; due to a collision with a 1954 mercury		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) skull with comminuted fracture		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" 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.) Injuries received in automobile
--	--

20c. TIME OF INJURY Hour Month, Day, Year 0:30 a.m. 8/21/58	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) collision	20e. CITY, TOWN, OR LOCATION 094	COUNTY St. Francois	STATE MO.
--	---	--	-------------------------------	---------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) US Highway #67	20f. CITY, TOWN, OR LOCATION St. Francois	COUNTY St. Francois	STATE MO.
---	--	---	-------------------------------	---------------------

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Bert Miller	(Degree or title) Coroner	22b. ADDRESS Farmington, MO	22c. DATE SIGNED 9/21/58
--------------------------------------	-------------------------------------	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 8/24/58	23c. NAME OF CEMETERY OR CREMATORY Williams	23d. LOCATION (City, town, or county) (State) Clay Co., Arkansas
--	-----------------------------	---	--

24. FUNERAL DIRECTOR Russell-Ermert	ADDRESS Corning, Ark.	25. DATE RECD. BY LOCAL REG. Sept. 21, 1958	26. REGISTRAR'S SIGNATURE Cather Rudloff
---	---------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

SEP 24 1959

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. T. Boyer*
Licensed Embalmer No. *3660*
P. O. Address *Leesburg, Va.*

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.