

THE DIVISION OF HEALTH OF MISSOURI -
STANDARD CERTIFICATE OF DEATH

58-045600

STATE FILE NUMBER

FILED JAN 5 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12048

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|--|---------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 39 HOSPITAL OR INSTITUTION Enroute to City Hospital | | Length of stay in lb Hospital 1247 | | d. STREET ADDRESS (If outside, give location) 3820 Wisconsin | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last FLOYD GARLAND DUNN | | | | 4. DATE OF DEATH Month Day Year 12 12 1958 | | | |
| 5. SEX Male <input checked="" type="checkbox"/> | 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 8-25-1903 | 9. AGE (In years and birthday) 55 | 10. UNDER 1 YEAR Months Days | 11. UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder American Car-Foundry | | | 10b. KIND OF BUSINESS OR INDUSTRY American Car-Foundry | | 11. BIRTHPLACE (City and state or country) Loogoote, Ill | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13a. FATHER'S NAME George Dunn | | | 13b. MOTHER'S MAIDEN NAME Ida Stein | | 14. NAME OF HUSBAND OR WIFE Mary 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. ? | | 17. INFORMANT Mary Dunn, 3820 Wisconsin Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gunshot wound of skull to brain</i> | | | | | | INTERVAL BETWEEN ONSET OF DEATH | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <i>E 976X</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>self inflicted in garage</i> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (E.g., nature of injury in PART I or PART II of item 18.) <i>up rear of head in garage 12. 1958, exact time unknown</i> | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. 12 12 58 p.m. | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, shop, street, office bldg., etc.) <i>Garage</i> | | 20f. CITY, TOWN, OR LOCATION St. Louis Mo | | STATE | |
| 21. I attended the deceased from _____ 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 <i>Joseph Emmerich</i> | | | | 22b. ADDRESS 1300 Chest | | 22c. DATE SIGNED 12/15/58 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 12-15-58 | 23c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cem. | | 23d. LOCATION (City, town, or country) (State) St. Louis Co., Missouri | | |
| 24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette | | | | 25. DATE RECD. BY LOCAL REG. DEC 15 '58 | | 26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> M. J. B. | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *James R. Chapman*
Licensed Embalmer No. *4550*
P. O. Address *St. Louis*

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.