

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000944

STATE FILE NUMBER

FILED JAN 26 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 70

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Greene</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Texas</b> b. COUNTY <b>BEXAR</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>San Antonio</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Medical Center for Federal Prisoners</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) - - - - -		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Jack</b> Middle <b>Irvin</b> Last <b>Dunlap</b>			4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 5, 1905</b>		9. AGE (In years, months, days, hours, minutes) <b>54</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>	11. BIRTHPLACE (City and state or country) <b>Moore, Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>John Dunlap (Deceased)</b>		13b. MOTHER'S MAIDEN NAME <b>Lucy Vaughn Dunlap</b>		14. NAME OF HUSBAND OR WIFE - - - - -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Files-MCFP, Springfield, Missouri</b> 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) <b>Pulmonary Edema</b>					INTERVAL BETWEEN ONSET AND DEATH <b>14 Days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Carcinoma of the Right Lung.</b>					10 Months
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? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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.) - - - - -		
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>			- - - - -		
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <input type="checkbox"/> STATE <input type="checkbox"/>
21. I attended the deceased from <b>The Medical Staff</b> <b>4-17-58</b> to <b>1-20-59</b> and last saw <b>him</b> alive on <b>January 20, 1959</b> Death occurred at <b>12:05 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>J. D. Hunter, M.D.</b>			22b. ADDRESS <b>Medical Center for Federal Prisoners, Springfield, Mo.</b>		22c. DATE SIGNED <b>1-20-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Jan. 21, 59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>		23d. LOCATION (City, town, or county) (State) <b>Devine, Texas</b>	
24. FUNERAL DIRECTOR <b>AYRE-GOODWIN: Springfield, Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>1-22-59</b>	26. REGISTRAR'S SIGNATURE <b>Effie E. Melton</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

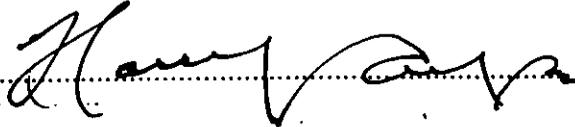
MEDICAL CERTIFICATION

Attending physician, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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  .....

Licensed Embalmer No. 4594 .....

P. O. Address Springfield, 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.