

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001273
STATE FILE NUMBER 246

FILED JAN 28 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300
1-57

| | | | | | | | | | |
|---|-------------------------------|---|---|--|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Kansas City</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>417 S. Bellaire</u> | | | Length of stay in lb. <u>65 yrs. 3</u> | | d. STREET ADDRESS (If outside, give location) <u>417 S. Bellaire</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Delora</u> Middle <u>Frances</u> Last <u>Dunn</u> | | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>11</u> Year <u>1959</u> | | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March-13-1878</u> | | 9. AGE (In years at birth) IF UNDER 1 YEAR Months <u>80</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u> IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u> | | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u> | | 11. BIRTHPLACE (City and state or country) <u>Lee's Summit Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>David S. Amett</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Martha E. Johnson</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Fred Dunn</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Ms. Gertrude Roelker</u> | | | Address <u>417 S. Bellaire</u> <u>15. E. Mo.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ | | | 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 type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____ | | | | | | | | | |
| 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 | |
| 21. I attended the deceased from _____, to _____, and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE <u>Neva Marshall</u> | | | (Degree or title) <u>3</u> | | | 22b. ADDRESS <u>1024 Pratt Blvd</u> | | 22c. DATE SIGNED <u>1-14-59</u> | |
| 23a. BURIAL, CREATION, REMOVAL (Specify) | | 23b. DATE <u>Jan. 15-1959</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u> | | 23d. LOCATION (City, town, or county) <u>Kansas City, Mo.</u> | | (State) | |
| 24. FUNERAL DIRECTOR <u>C. H. Blackman</u> | | | ADDRESS <u>1509 W. 100th St.</u> | | 25. DATE RECD. BY LOCAL REG. <u>1-15-59</u> | | 26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u> | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

High H. Owens

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 Wayne Smith....., Student Embalmer No. 567..... working under my personal supervision.

Student Wayne Smith.....
Signature of Student Embalmer

Signed W.C. Reine.....

Licensed Embalmer No. 4899.....

P. O. Address W.C. Reine.....

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.