RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS SEP 4 1959

59-030357

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7833

NDED

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 — Length of stay in 1b 10 Days

c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Park Lane Hospital — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 4118 Westminister — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Bertha Middle M. Last Dunnagan

4. DATE OF DEATH Month 8-2[illegible]-59 Day Year

5. SEX Female

6. COLOR OR RACE White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 4-7-04

9. AGE (last birthday) 55 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home

10b. KIND OF BUSINESS OR INDUSTRY Housewife

11. BIRTHPLACE (City and state or country) Eddieville, Ky

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME David M. Lovell

13b. MOTHER'S MAIDEN NAME Rosie Cannon

14. NAME OF HUSBAND OR WIFE Edward C. Dunnagan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None

17. INFORMANT Edward C. Dunnagan Address St. Louis,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Pregnant Breast — INTERVAL BETWEEN ONSET AND DEATH 2 years

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 June 1st 59, to 8-21-59 and last saw her alive on 8-21-59
Death occurred at 12:30 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Clyde B. Kane (Degree or title) M.D.

22b. ADDRESS 706 Walton

22c. DATE SIGNED 8-22-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 8-25-59

23c. NAME OF CEMETERY OR CREMATORY Fosterberg Cemetery

23d. LOCATION (City, town, or county) (State) Fosterberg, Ill.

24. FUNERAL DIRECTOR White-Mullen ADDRESS 118 N. Florissant Rd.

25. DATE RECD. BY LOCAL REG. AUG 24 '59

26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4329

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.