

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025545

FILED VS JUN 29 1960 356

4521

51

STATE FILE NUMBER

Registration District No. 356 Primary Registration District No. 4521 Registrar's No. 51

DED

1. PLACE OF DEATH a. COUNTY <b>Texas</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Texas</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Houston</b>		Length of stay in 1b		c. CITY OR TOWN <b>Houston</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Texas County Mem. Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Dewey</b> Last <b>Dunn</b>				4. DATE OF DEATH Month <b>6</b> Day <b>23</b> Year <b>60</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/19/1900</b>	9. AGE (last birthday) <b>60</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. construction work &amp; Farming</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Tuckerman, Arkansas</b>		11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <b>Joseph E. Dunn</b>			13b. MOTHER'S MAIDEN NAME <b>Dora Cagle</b>			14. NAME OF HUSBAND OR WIFE <b>Hazel</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>486-18-4545</b>		17. INFORMANT Address <b>Mrs. Hazel Dunn, Houston, Mo.</b>			
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>Acute Pulmonary Insufficiency</b> DUE TO (b) <b>Chronic Severe Bronchial Catarrh</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>36 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 <b>6-22-60</b> to <b>6-23-60</b> and last saw him alive on <b>6-23-60</b> Death occurred at <b>9:15 a.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Joe A. Wall MD</b> (Degree or title)			22b. ADDRESS <b>Houston, Missouri</b>			22c. DATE SIGNED <b>6-25-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/25/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Vollmar Cemetery</b>		23d. LOCATION (City, town, or county) <b>Texas County, Missouri</b>		(State)		
24. FUNERAL DIRECTOR <b>Raymond E. Duff, Houston, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>6-27-60</b>		26. REGISTRAR'S SIGNATURE <b>Myrtle Craig</b>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Frank E. Hood

Licensed Embalmer No. 402

P. O. Address Houston

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.