

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 19 1960

**=60-026099**

STATE FILE NUMBER

DED

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 195

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Callaway</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		a. STATE <b>Mo.</b>		b. COUNTY <b>Callaway</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>710 Court</b>		Length of stay in 1b <b>60yrs.</b>		c. CITY OR TOWN <b>Fulton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>710 Court</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>Margaret</b>		Middle <b>Elizabeth</b>		Last <b>Dunn</b>		Month Day Year <b>July 10 1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3-18-1869</b>	9. AGE (last birthday) <b>91</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (City and state or country) <b>Morgan Co. Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Zadock Leebrick</b>			13b. MOTHER'S MAIDEN NAME <b>Pamela Thomas</b>			14. NAME OF HUSBAND OR WIFE <b>John Dunn</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>None</b>		17. INFORMANT <b>Mrs. David Hopkins</b>		Address <b>Fulton Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b>						<b>20 years</b>	
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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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>9-26-54</b> to <b>7-10-60</b> and last saw her alive on <b>7-9-60 19:1960</b> Death occurred at <b>July 10, 1960 4 A</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Vernon H. Grogan, D.C.</b>				22b. ADDRESS <b>215 Market St Fulton, Mo.</b>		22c. DATE SIGNED <b>7-11-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-11-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Callaway Mem. Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Callaway Co. Mo.</b>	
24. FUNERAL DIRECTOR <b>Maupin Funeral Home</b>		ADDRESS <b>Fulton</b>		25. DATE RECD. BY LOCAL REG. <b>July 12-1960</b>		26. REGISTRAR'S SIGNATURE <b>Maretha Lawrence</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 J. V. Rosson

Licensed Embalmer No. 2550

P. O. Address Hulton

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.