

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-007356

STATE FILE NUMBER

AMENDED

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Vernon</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Nevada</b>		c. CITY OR TOWN <b>Nevada</b>	
Length of stay in 1b <b>15 Yrs.</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>City Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>1123 E. Division</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Opal</b> Middle <b>Leora</b> Last <b>Dunfield</b>			4. DATE OF DEATH Month <b>2</b> Day <b>19</b> Year <b>61</b>
5. SEX <b>f</b>	6. COLOR OR RACE <b>w</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>7/9/08</b>
9. AGE (last birthday) <b>52</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>Housewife</b>	11. BIRTHPLACE (City and state or country) <b>Lamine, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Elvin Wright</b>	
13b. MOTHER'S MAIDEN NAME <b>Sirena Carpenter</b>		14. NAME OF HUSBAND OR WIFE <b>William Dunfield</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>William Dunfield, Nevada Mo</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>Meningitis, pneumococcal</b>			INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b>
DUE TO (b) <b>Right middle ear infection - 4 days prior</b>			<b>4 days</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) <b>Diabetes mellitus, chronic interstitial nephritis with hypertension.</b>			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>Feb. 18, 1961</b> to <b>Feb. 19, 1961</b> and last saw her <sup>her</sup> <sub>200</sub> alive on <b>Feb. 19, 1961</b> Death occurred at <b>Nevada, Mo.</b> <b>7:16 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>R. B. Wray, M.D.</i>		22b. ADDRESS <b>Moore Bldg., Nevada, Mo.</b>	22c. DATE SIGNED <b>2/24/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/21/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moore Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Nevada, Mo.</b>
24. FUNERAL DIRECTOR <b>Richard L. Shorten, Nevada, Mo</b>		25. DATE REGD. BY LOCAL REG. <b>Feb 28-1961</b>	26. REGISTRAR'S SIGNATURE <i>Anna E. Ferry</i>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed *Richard C. McLeod*

Licensed Embalmer No. 4853

P. O. Address Florida, 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.