

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE 318 Primary Registration District No. 1003 Registrar's No. 5853 STATE FILE NUMBER -61-022492

DATE AMENDED
INSTEAD OF
BY AFFIDAVIT OF
ITEM NO.

AMENDED
Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 5853 STATE FILE NUMBER -61-022492

FILED JUL 13 1961

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis** Length of stay in 1b _____
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION **St. Louis City Hosp. #1** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Mo.** b. COUNTY _____
c. CITY OR TOWN **St. Louis** Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) **3302 So. Broadway** Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
LESLIE DUNN **JUNE 21, 1961**

5. SEX **Male** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **6-21-1961** 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min. **4**

10a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 10b. KIND OF BUSINESS OR INDUSTRY **Infant** 11. BIRTHPLACE (City and state or country) **St. Louis, Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **Bobby Dunn** 13b. MOTHER'S MAIDEN NAME **Marie Clark** 14. NAME OF HUSBAND OR WIFE **None**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT Address **Berth Clark 3302 S. Broadway**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **IMMATURITY**
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____
DUE TO (c) _____ **776x**
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 **6/21/1961** to **6/21/1961** and last saw him alive on **6/21/1961**
Death occurred at **6:45 A.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Wilma Claxman M.D.** 22b. ADDRESS **1515 Lafayette** 22c. DATE SIGNED **6/21/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **6/23/1961** 23c. NAME OF CEMETERY OR CREMATORY **St. Trinity Cemetery** 23d. LOCATION (City, town, or county) (State) **St. Louis Co., Mo.**

24. FUNERAL DIRECTOR ADDRESS **McLaughlin Funeral Home 2301 Lafayette** 25. DATE RECD. BY LOCAL REG. **6-23-61** 26. REGISTRAR'S SIGNATURE **Loan Smith, M.D.**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{npt} embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. G. Farris

Licensed Embalmer No. 3384
P. O. Address Louis, 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.