

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030463  
STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 197

AMENDED

ED AUG 17 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in 1b <u>10 weeks</u>	c. CITY OR TOWN <u>Overland</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>10418 Eaglewood Dr.,</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Roger</u> Middle <u>Harold</u> Last <u>Tunnell</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>5,</u> Year <u>1961</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-1927</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ozark Airlines</u>	9. AGE (last birthday) <u>34</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ IF UNDER 24 HR: Min. _____
11. BIRTHPLACE (City and state or country) <u>Litchfield, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Harold Tunnell</u>		13b. MOTHER'S MAIDEN NAME <u>Dorothy Goff</u>	14. NAME OF HUSBAND OR WIFE <u>Juanita J. Tunnell</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW #2</u>		17. INFORMANT <u>Juanita J. Tunnell-10418 Eaglewood</u> Address <u>Overland 14</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized carcinoma atosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>carcinoma of the rectum</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>not known</u>
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 <u>6-5-61</u> to <u>8-5-61</u> and last saw <sup>her</sup> him alive on <u>8-5-61</u> Death occurred at <u>8:05 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Arne E. Carlson</u> (degree or title) <u>M.D.</u>		22b. ADDRESS <u>3109 Brown Rd. Overland Mo</u>	22c. DATE SIGNED <u>8-7-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>8-8-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Litchfield, Illinois</u>
24. FUNERAL DIRECTOR <u>Baumann Bros. Inc. 2504 Woodson Rd.</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 7, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mareeela Wilson</u>

AUG 18 1961

**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 David C. Gibson

Licensed Embalmer No. 3454  
P. O. Address Orlando

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.