

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032162

STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. \_\_\_\_\_ Registrar's No. 159

FILED OCT 2 1961

1. PLACE OF DEATH a. COUNTY <b>Cass</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mt Pleasant Township</b>		Length of stay in 1b <b>3 Days</b>	c. CITY OR TOWN <b>Olathe</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>328th USAF Hospital Richards-Gebaur AFB, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>114 N Keeler</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle _____ Last <b>Dunn</b>			4. DATE OF DEATH Month <b>September</b> Day <b>24</b> Year <b>1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</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 Jan 82</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>United States</b>	
13a. FATHER'S NAME <b>Thomas Dunn</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>May L. 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>	17. INFORMANT <b>Walter H Dunn (Son)</b>	Address <b>615 Troost Olathe, Kansas</b>
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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>Coronary thrombosis</b>		<b>Immediate</b>
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		<b>14 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>Congestive Heart Failure</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 21 Sep 61 to 24 Sep 61 and last saw him alive on 24 Sep 61  
Death occurred at 1:32 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C.N. Owensby</i> <b>C.N. OWENSBY, Capt., USAF, MC</b>	(Degree or title)	22b. ADDRESS <b>328th USAF Hospital Richards-Gebaur AFB, Mo.</b>	22c. DATE SIGNED <b>24 Sep 61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Sept. 25, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Olathe Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Olathe, Kansas</b>
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24. FUNERAL DIRECTOR <b>Julien-Flaming Funeral Home</b>	ADDRESS <b>Olathe, Kan.</b>	25. DATE RECD. BY LOCAL REG. <b>Sept 25-1961</b>	26. REGISTRAR'S SIGNATURE <i>McRay Sebra</i>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDED  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

OCT 3 1961

name of person

x

name of person

days

place of death

x

name of person

x

name of person

DDI

name of person

name of person

name of person

x

name of person

**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 *Arthur L. Fleming*  
Licensed Embalmer No. 4569

P. O. Address *Arthur L. Fleming*

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.