

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035953

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 1123

STATE FILE NUMBER

AMENDED

FILED NOV 13 1961

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph			Length of stay in 1b 12 years		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 1124 North Fifth			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1912 North Third		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Charles Edgar Dunn				4. DATE OF DEATH Month Day Year November 3, 1961			
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-11-85	9. AGE (last birthday) 76	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) laborer		10b. KIND OF BUSINESS OR INDUSTRY creamery		11. BIRTHPLACE (City and state or country) Rulo, Nebraska		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME Seth Dunn			13b. MOTHER'S MAIDEN NAME Fanny Chaney			14. NAME OF HUSBAND OR WIFE Martha Ann Dunn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				17. INFORMANT Address Donald W. Dunn, 1912 North Third St. Joseph, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Artery Disease							INTERVAL BETWEEN ONSET AND DEATH 46 m.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) Arteriosclerosis, Gen. & Pulmonary Fibrosis		Yes <input checked="" type="checkbox"/>		
			DUE TO (c) Bronchial Asthma Acute Recurr.		Yes <input checked="" type="checkbox"/>		
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 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 checked="" 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 2-27-58 to 11-3-61 and last saw him alive on 10-25-61 Death occurred at 4:45 PM m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Robert W. Keefer, M.D.</i> (Degree or title)				22b. ADDRESS St. Joseph, Mo.		22c. DATE SIGNED 11-6-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 11-3-61	23c. NAME OF CEMETERY OR CREMATORY Catron Cemetery		23d. LOCATION (City, town, or county) (State) Fortesque, Missouri		
24. FUNERAL DIRECTOR BREIT & HAWKINS SAVANNAH			ADDRESS		25. DATE RECD. BY LOCAL REG. Nov. 7, 1961	26. REGISTRAR'S SIGNATURE <i>Miss Clark Goodell</i>	

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

R.W. Keefer, M.D.

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 James P. Hawkins

Licensed Embalmer No. 4531

P. O. Address Savannah

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.