

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037652

STATE FILE NUMBER

AMENDED

Registration District No. 487 Primary Registration District No. 3040 Registrar's No. 176

FILED OCT 16 1961

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		c. CITY OR TOWN <u>Rural Monroe Twp.</u>	
Length of stay in 1b <u>3 Days</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chillicothe Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>3 Mi. South Gallatin</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>LeRoy</u> Last <u>Dunnington</u>			4. DATE OF DEATH Month <u>September</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1876</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>	IF UNDER 24 HR Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (City and state or country) <u>Daviess Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>James Dunnington</u>		13b. MOTHER'S MAIDEN NAME <u>Joanna Worley</u>		14. NAME OF HUSBAND OR WIFE <u>Austa Dunnington (Dec'd)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>    </u>		17. INFORMANT <u>Lindley Dunnington, Gallatin, Mo.</u>		

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) <u>Pneumonia Terminal</u>		<u>1 day</u>
DUE TO (b) <u>Fractured R hip</u>		<u>4 days</u>
DUE TO (c) <u>Arterial Sclerosis</u>		<u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fractured hip nailed Sept 20 61</u>		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 <u>    </u> Month, Day, Year <u>    </u> p.m. <u>    </u>		

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 <u>    </u>	COUNTY <u>    </u>	STATE <u>    </u>
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21. I attended the deceased from Sept. 19 '61 to Sept. 22 '61 and last saw her alive on Sept. 22 '61  
Death occurred at 9:14 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Joseph Conrad M.D.</u>	(Degree or title)	22b. ADDRESS <u>Chillicothe, Mo</u>	22c. DATE SIGNED <u>Oct. 11 '61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-25-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brown Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Gallatin, Missouri</u>

24. FUNERAL DIRECTOR <u>Hope Funeral Home, Gallatin, Mo.</u>	ADDRESS <u>    </u>	25. DATE RECD. BY LOCAL REG. <u>Oct 11 1961</u>	26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 L. O. Lichesson

Licensed Embalmer No. 3302

P. O. Address Dollator,

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.