

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

278-63-019315
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 278

FILED JUN 10 1963

VS 300
Rev. 4/59

1 0168
2 1001
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4 1
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9 43X
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12 2-0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>CAPE</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAPE GIRARDEAU</u> | | Length of stay in 1b <u>18 days</u> | |
| c. FULL NAME OF (If NOT in hospital; give location) HOSPITAL OR INSTITUTION <u>St. FRANCIS-HOSP.</u> | | d. STREET ADDRESS (If outside, give location) <u>310 EAST YORKUM AVE.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>(NMN)</u> Last <u>DUNN</u> | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>29</u> Year <u>1963</u> | |
| 5. SEX <u>FEMALE</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>MAY 13 1884</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | 11. BIRTHPLACE (City and state or country) <u>JACKSON, MISSOURI</u> |
| 13a. FATHER'S NAME <u>HENRY TOTTEN</u> | | 13b. MOTHER'S MAIDEN NAME <u>BELLE COX</u> | 14. NAME OF HUSBAND OR WIFE <u>GEORGE W. DUNN</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>NO</u>) | | 16. SOCIAL SECURITY NO. <u>—</u> | 17. INFORMANT Address <u>MRS. JOSIE GRIFFIN - CHAFFEE, Mo.</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>Chr. Hypertensive Myocarditis</u> <u>Old Cerebral Hemorrhage (Left Arm & Leg Paralysis)</u> DUE TO (c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yr</u> <u>4 yr</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Rt. Side - Bronchial Pneumonia 17 days.</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> and p.m. <u>—</u> Month, Day, Year <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 COUNTY STATE | |
| 21. I attended the deceased from <u>7-18-59</u> to <u>5-29-63</u> and last saw her <u>alive</u> on <u>5-29-63</u> Death occurred at <u>7:55 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Deedee or title) <u>William J. Oehler, M.D.</u> | | 22b. ADDRESS <u>Cape Girardeau Mo.</u> | |
| 22c. DATE SIGNED <u>5-31-63</u> | | 23d. LOCATION (City, town, or county) (State) <u>Delta Missouri</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>JUNE 1, 1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>KYNION CEMETERY (NEAR) DELTA, MISSOURI</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>BISPLINGHOFF FUNERAL HOME - CHAFFEE, Mo. 6-3-63</u> | | 25. DATE RECD. BY LOCAL REG. <u>—</u> 26. REGISTRAR'S SIGNATURE <u>James Kuster</u> | |

USE BLACK INK OR TYPEWRITER RIBBON

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 Jack T. Burnett

Licensed Embalmer No. 4473

P. O. Address Chaffee, Missouri

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.