

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

67 0037988

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 336 Primary Registration District No. 4493 Registrar's No. 14

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 16 1967

1. PLACE OF DEATH a. COUNTY <u>Shannon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Birch Tree</u>		Length of stay in 1b	c. CITY OR TOWN <u>Birch Tree</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>Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Chester</u> Middle <u>Earl</u> Last <u>Dunn</u>			4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1967</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>3/1/1913</u>	9. AGE (last birthday) <u>54</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Disabled</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Winona, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>James Arthur Dunn</u>		13b. MOTHER'S MAIDEN NAME <u>Nova Mast Barton</u>		14. NAME OF HUSBAND OR WIFE	
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>500-10-3761</u>	17. INFORMANT Address <u>James A. Dunn Birch Tree, Missouri</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>Congestive Heart Failure</u>		
DUE TO (b) <u>Cox Pulmonale</u>		
DUE TO (c) <u>Severe Pulmonary Emphysema</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Bronchitis</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 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 4-25-67 to 10-4-67 and last saw <sup>her</sup>him alive on 10-4-67  
Death occurred at 4:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>G. Franklin Smith, M.D.</u>	(Degree or title)	22b. ADDRESS <u>Willow Springs, Mo</u>	22c. DATE SIGNED <u>10-10-67</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/7/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Forest Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Birch Tree, Missouri</u>
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24. FUNERAL DIRECTOR <u>Duncan Funeral Home Mtn. View, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Oct 13, 1967</u>	26. REGISTRAR'S SIGNATURE <u>Walter Adams</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

1 / 010

2 / 1010

3

4 / 0

5 / 2

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11

12 / 90-0

13 / 1-0

OCT 19 1967

Bruce Bennett - Paris to Bunnell

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 Joe R. Duncan

Licensed Embalmer No. 4325

P. O. Address Yonkers, N.Y.

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.