

REC'D APR 13 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

## 1. PLACE OF DEATH

County *Atchison*Registration District No. *19*Township *Clay*Primary Registration District No. *5025*

City

(No. *1*)File No. *9892*

Registered No.

## 2. FULL NAME

(a) Residence, No. *541*

St.

Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*male*

## 4. COLOR OR RACE

*white*

## 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

*Married*

## 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

## 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

*May 23, 1874*

## 7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

*64**10**6*

## 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

*Labourer*

## 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

*11*

## 10. Date deceased last worked at this occupation (month and year)

## 11. Total time (years) spent in this occupation

## 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

*Michigan*

## 13. NAME

*Unknown*

## 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

*Unknown*

## 15. MAIDEN NAME

*Unknown*

## 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

*Unknown*

## 17. INFORMANT

(ADDRESS)

*Jesse Dunlap*

## 18. BURIAL, CREMATION, OR REMOVAL

PLACE *Central Burial* DATE *Mar 21 1939*

## 19. UNDERTAKER

(ADDRESS)

*C. E. Pyburn*

## 20. FILED

*9-28 1939*Registrar. *16*

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 28, 1939*22. I HEREBY CERTIFY, That I attended, deceased from *March 15, 1939, to March 28, 1939*I last saw him alive on *March 28, 1939*. Death is said to have occurred on the date stated above, at *10:30 p.m.*

The principal cause of death and related causes of importance were as follows:

*Pneumonia Fere*

Date of onset

Other contributory causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify

(Signed) *Wiegman R. Stuckard*, M. D.(Address) *Rockport, Mo.*

UNLAWFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

104

RECEIVED

District Health Officer-No. 111

District File Number. 39-309

Date Filed - APR 11 1939

SEP 23 1946

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

9892  
Do not use this space.

1. PLACE OF DEATH

(a) County Atchison Registration District No. 19  
(b) Township Clay Primary Registration District No. 2025- Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Clarence Gilispie Dunlap  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED ( <i>write the word</i> ) <u>m</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>64</u>	MONTHS <u>10</u>	DAYS <u>6</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL				
PLACE _____ DATE _____ 19__				
19. FUNERAL DIRECTOR (ADDRESS)				
20. FILED _____ 19__				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-28-1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

*Pneumonia fever*  
*Bronchial pneumonia*  
*trichinosis*  
*W.H. Strickland M.D.*  
*1972*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) Wm. R. Strickland, M. D.

(Address) Bockport Mo

Local Registrar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

MAY - 3 1969