

No. 2
-13-40
-17-39
K 23159

FILED OCT 18 1940
Registration District No. **237**

Primary Registration District No. **4508**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **Stoddard**
 (b) City or town **Bloomfield, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **None**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ **20**
(Specify whether)
 In this community _____ **Years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Stoddard**
 (c) City or town **Bloomfield, Mo.**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME **MATTIE A. DUNN**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
 6. (b) Name of husband or wife **W. Dunn** 6. (c) Age of husband or wife if alive **Deceased** years
 7. Birth date of deceased **Feb. 7, 1868**
(Month) (Day) (Year)

8. AGE: Years **72** Months **7** Days **19** If less than one day _____ hr. _____ min.

9. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Theodore Westenhaber**

13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name **Kathryn Hurn**
(City, town, or county) (State or foreign country)

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **James M. Dunn**
 (b) Address **Bloomfield, Missouri.**

17. (a) Burial (b) Date thereof **9-26-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **West Antioch cem.**

18. (a) Signature of funeral director **Chiles Und. Co.**
 (b) Address **Bloomfield, Mo.**

19. (a) Sept-28-40 (b) **Loonie Church**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **26th**
 year **1940** hour **3:45 a.m.** minute _____ M.

21. I hereby certify that I attended the deceased from **Sept. 21**, 19**40**, **Sept. 26**, 19**40**;
 that I last saw him alive on **Sept. 26**, 19**40**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Haemorrhage** Duration 4 hrs
 Due to **Cancer of face might have been contributing cause.**
 Due to **N.M.D.**

Other conditions **Suffered burn on face about 9/21/40**
(Include pregnancy within 3 months of death)

Major findings **Not Contributing**
 Of operations _____

Of autopsy **SA**

PHYSICIAN

 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
895
(Specify type of place) While at work? _____ (g) Means of injury _____

23. Signature **John Wilson** (M. D. or other) _____
 Address **Bloomfield, Mo.** Date signed **9/27/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

3
4
9

RECEIVED

District Health Officer No. 2,

District File Number 1040-155

Date Filed 10/10/40

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.....

....., Registered Apprentice No.....

.....
working under my personal supervision.

Signed Deceased was not embalmed.

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.