

Registration District No. 1703

Primary Registration District No. 6186

Registrar's No.

1. PLACE OF DEATH:

(a) County Washington  
(b) City or town Sullivan, Rural  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 Months.  
In this community 2 Months.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Washington  
(c) City or town Sullivan, Rural  
(d) Street No.  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Eldon Joseph Dunakey

8. (b) If veteran, name war Child 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive

7. Birth date of deceased July 8 1940  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
2 21 hr. min.

9. Birthplace Washington Co., Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business

12. Name Joseph Dunakey  
13. Birthplace Morrelton Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Viola Dickson  
15. Birthplace St. Louis, Missouri.  
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph Dunakey  
(b) Address Sullivan, Missouri.

17. (a) St Burial No. (b) Date thereof Sep. 30, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Stanton, Missouri.

18. (a) Signature of funeral director Self.  
(b) Address

19. (a) 10-1-40 (b) T D Harmon  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sep. day 29, 1940.  
year 1940 hour 5 minute PM.

21. I hereby certify that I attended the deceased from 9-22-1940 to 9-29-1940  
that I last saw him alive on 9-29- 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death acute diarrhoea

Due to 1140

Other conditions Marasmus  
(Include pregnancy within 3 months of death)

Major findings: None  
Of operations  
Of autopsy None

Duration

2 wks

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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature [Signature] (M. D. or other)  
Address Sullivan Date signed 9/30/40

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

MOTHER FATHER

**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.....

Not Embalmed.

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

working under my personal supervision.

Signed.....

.....  
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, above space should be left blank.**

121