

ED JUN 7 1943

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson,

(b) City or town Kansas City,

(c) Name of hospital or institution: Menorah Hospital, 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether  
In this community 5 days years, months or days)

3. (a) PRINT FULL NAME Arch R. Dunbar,

3. (b) If veteran, name war World War

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Margaret Dunbar,

6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>54</u>			hr. min.

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

10. Usual occupation Commercial Canning

11. Industry or business X

12. Name Fred F. Dunbar,

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

14. Maiden name Agnes Mitchell,

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

16. (a) Informant Mrs. Margaret Dunbar,

(b) Address Des Moines, Iowa,

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-25-43  
(Month) (Day) (Year)

(c) Place: burial or cremation Des Moines, Iowa,

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 5-25-43 (Date received local registrar)

(b) M. N. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa, (b) County 999

(c) City or town Des Moines, 13  
(If outside city or town limits, write "RURAL")

(d) Street No. 2 (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25<sup>th</sup>  
year 1943 hour 3:00 minute PM.

21. I hereby certify that I attended the deceased from May 25  
1943 to May 27 1943  
that I last saw him alive on May 24 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to 83a

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

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?

While at work (Specify type of place) (City or town) (County) (State)

23. Signature [Signature] (M. D. or other) [Signature]  
Address 440 [Signature] Date signed [Signature]

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. Kovits  
3800 W. 67 St.

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**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.....  
*Clair Shippard*

Licensed Embalmer No..... *4179*

P. O. Address..... *H. C. mo.*

**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.**