No. 2
-9-4-41
5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 12 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37325

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 386

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No 1 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 yrs 1 m 5 d (Specify whether
In this community 80 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Callaway 14

(c) City or town Fulton 1 2
(If outside city or town limits, write "RURAL")

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

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

If yes, name country

3. (a) PRINT FULL NAME Mrs Eliza Dunn

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 1

5. Color or race White 2

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

6. (b) Name of husband or wife DK

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

7. Birth date of deceased Aug (Month) 3 (Day) 1864 (Year)

8. AGE: Years	Months	Days	If less than one day
80	3	17	hr. min.

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

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Samuel Boggess
13. Birthplace (City, town, or county) Ky (State or foreign country)

MOTHER
14. Maiden name Nancy Atkinson
15. Birthplace (City, town, or county) Va. (State or foreign country)

16. (a) Informant Record

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/44 (Month) (Day) (Year)

(c) Place: burial or cremation New Hope Ch. Cem

18. (a) Signature of funeral director Wallace Funeral Home

(b) Address Fulton, Mo. D. C. Browning Mgr.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Nov. day 20
year 1944 hour 6-20 minute P M.

21. I hereby certify that I attended the deceased from 7-1-44, 19, to 11-20-, 1944
that I last saw her alive on 11-20-, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	
Due to Arteriosclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death) 93d	
Major findings: Of operations	
Of autopsy	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature R. E. Sherrill (M. D. or other) M.D.

Address Fulton Mo Date signed 11/20/44

1141

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 12-11-44

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 Dengil A. Browning

Licensed Embalmer No. 2724

P. O. Address Fulton Ohio

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 386

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)

(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 (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Eliza Dunn

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 3 (Day) 1864 (Year)

8. AGE: Years 80 Months 3 Days 17 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 11-21-1944 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 20 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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(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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

37325