S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41197

FILED JAN 15 1946

Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 1003

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Rural, S. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
RFD# 3, ~~Springfield, Mo~~
(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 Missouri (b) County Greene

(c) City or town Rural - Springfield - S. Campbell Twp.
(If outside city or town limits, write "RURAL")

(d) Street No. RFD# 3, ~~Springfield, Mo.~~
(If rural, give location)

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

If yes, name country

39

0

0

0

3. (a) PRINT FULL NAME Dr. Bert Lawson Dunnington

3. (b) If veteran, name war UNK.

3. (c) Social Security No. UNK.

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Susan N. Dunnington

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

7. Birth date of deceased September (Month) 30, (Day) 1881 (Year)

8. AGE: Years 64 Months 2 Days 7 If less than one day hr. min.

9. Birthplace Quincy, (City, town, or county) Illinois / (State or foreign country)

10. Usual occupation retired Osteopathic Doctor

11. Industry or business Medicine

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

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

16. (a) Informant Mrs. Susan Dunnington
(b) Address RFD# 3, Springfield, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/1945 (Month) (Day) (Year)
(c) Place: burial or cremation East Lawn Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
(b) Address Springfield, Missouri

19. (a) 12-11-45 (Date received local registrar) (b) S W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 7, year 1945 hour 1: minute 00 P. M.

21. I hereby certify that I attended the deceased from IN 1942, 19 to , 19 that I last saw him alive on DEAD ON 12-7 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis He was found dead outside his house by his wife & daughter

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Duration

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 T M King DO 2 (M. D. or other)

Address Springfield Mo Date signed 12-10-45

988

(Licensed Embalmer's Statement on Reverse Side)

JAN 16 1945

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.....

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.