

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19688
Registrar's No. 1079

Registration District No. 377 Primary Registration District No. 6076

1. PLACE OF DEATH:
(a) County St. Louis Rural
(b) City or town Koch Rural
(c) Name of hospital or institution: Koch Hospital D.
(d) Length of stay: In hospital or institution 1707 days
In this community ENTIRE LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 000
(c) City or town St. Louis 129
(d) Street No. 2717 DAYTON
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME DUNN, ARTHUR
3. (b) If veteran, name war. No
3. (c) Social Security No. NONE

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 5 day 9
year 47 hour 4 minute 15 P.M.
21. I hereby certify that I attended the deceased from 4-9-47 to 5-9-47
that I last saw him alive on 5-9-47
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color of race NEGRO
6. (a) Single, widowed, married, divorced, or married MARRIED
6. (b) Name of husband or wife MABEL DUNN
6. (c) Age of husband or wife if alive 23 years
7. Birth date of deceased 8 23 1900 (Month) (Day) (Year)

Immediate cause of death CHRONIC PULMONARY TUBERCULOSIS About 3 yrs.
Duration
Due to 130

8. AGE: Years 46 Months 8 12 Days - If less than one day hr. min.

9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)
10. Usual occupation VENDOR

11. Industry or business TOM DUNN
12. Name TOM DUNN
13. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)
14. Maiden name JULIE DAVIS
15. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)

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.

16. (a) Informant Hosp. RECORDS
(b) Address Koch Hosp. Koch Mo
17. (a) Burial (Burial, cremation, or removal) Washington Park
(b) Date thereof 5-15-47 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director J.H. Randle & Son
(b) Address 3133 Bell Ave
19. (a) 5-19-47 (Date received local registrar)
(b) Ceira J. Shuff MD (Registrar's Signature)

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) (e) Means of injury
23. Signature Bernard Friedman (M. D. or other M.D.)
Address Koch Hosp. Koch Mo. Date signed 5-9-47

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

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..... *J. Watson*
Licensed Embalmer No. *269A*
P. O. Address..... *2769 Chouteau*

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.