

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3705 Washington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 2 months
years, months or days)

3. (a) PRINT FULL NAME Chester C. Dunbar

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex male 5. Color or race white 6. (a) single, widowed, married, divorced 3

6. (b) Name of husband or wife Mary Jane Dunbar 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased August 30 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 11 13 hr. min.

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

10. Usual occupation Contractor

11. Industry or business _____

MOTHER FATHER { 12. Name Owen Dunbar /

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

14. Maiden name Mary Edminister

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

16. (a) Informant Mrs. Orma Renfro

(b) Address 3705 Washington

17. (a) Removal (b) Date thereof Aug. 15 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Basemor, Kansas

18. (c) Signature of funeral director [Signature]

(b) Address 7406 Wornall Rd.

19. (a) 8-15-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 3705 Washington 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 13
year 1947 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from Aug 7
1947, to Aug 13 1947
that I last saw him alive on Aug 13 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Pulmonary
Failure secondary to Chronic
Interstitial Nephritis
Chronic Interstitial Nephritis
Due to Chronic Interstitial Nephritis years
Due to _____ years
Other conditions (include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Major findings: _____
Of operations: 131a
Of autopsy: _____
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? _____

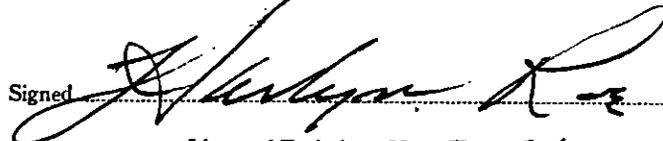
(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature [Signature] (M. D. or other) DO
Address 7427 Broadway, N.C. Date signed 8/15/47

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

2
45
39
47070

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. 7810
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.