

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Earl Dean Dunn

3. (b) If veteran, name war: _____

3. (c) Social Security No.: _____

4. Sex: Male **5. Color or race:** White

6. (a) Single, widowed, married, divorced: 0

6. (b) Name of husband or wife: _____

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

7. Birth date of deceased: 10-3-47
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	if less than one day
		<u>1</u>	<u>29</u> hrs <u>15</u> min.

9. Birthplace: St. Louis Mo. **0**
(City, town, or county) (State or foreign country)

10. Usual occupation: _____

11. Industry or business: _____

12. Name: Earl Leslie Dunn

13. Birthplace: Marston Mo. **0**
(City, town, or county) (State or foreign country)

14. Maiden name: Anola Irene Hutton

15. Birthplace: Van Buren Ark. **1**
(City, town, or county) (State or foreign country)

16. (a) Informant: Mother

(b) Address: 2608 So. 3rd St.

17. (a) BURIAL (b) Date thereof Oct 6-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: MEMORIAL PARK CEM

18. (a) Signature of funeral director: Walter Brink

(b) Address: 6736 Clayton Rd

19. (a) OCT 6 1947 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

(c) City or town St. Louis **17**
(If outside city or town limits, write "RURAL")

(d) Street No. 23 2608 So. 3rd **4**
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 4
year 1947 hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from: Oct 3, 1947 to Oct 4, 1947
that I last saw him alive on 4 October, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____

a) Respiratory failure
b) Cardiac failure c) Hypostatic pneumonia.

Due to Prematurity (7 mo. gestation)

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: NONE

Of autopsy: NONE

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): DOES NOT APPLY.

(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? 0

While at work _____ (Specify type of place)

Means of injury _____

23. Signature: Syrus D. Winter (M. D. or other) **2nd**

Address: 1325 S Grand Date signed 10-5-47

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 *Not Embalmed at All*.....

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.