

FILED JAN 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2623

BIRTH NO. _____		REG. DIST. NO. <b>318</b>	PRIMARY REG. DIST. NO. <b>1003</b>	Registrar's No. <b>18</b>
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY <b>ST LOUIS</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST LOUIS</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>OVERLAND</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST ANTHONY'S HOSP</b>		e. STREET ADDRESS (If rural, give location) <b>NK 3408 Lakes</b>		
3. NAME OF DECEASED (Type or Print) <b>Timothy DUNN Sr.</b>		a. (First) <b>Timothy</b>		b. (Middle) <b>DUNN Sr.</b>
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <b>JAN. 1 1949</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Sept 23 1866</b>	9. AGE (In years last birthday) <b>82</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>John DUNN</b>		13b. MOTHER'S MAIDEN NAME <b>Walsh</b>		14. NAME OF HUSBAND OR WIFE <b>Catherine</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Tim Dunn 8103 St. Charles Rd.</b>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pneumonia w/ lung lobes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unk.</b>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) <b>Arterio-sclerosis General</b>		
		DUE TO (c) <b>4-50.0/08</b>		
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Infection urinary tract</b> <b>Suppuration both lower extremities</b>		<b>swollen 3 days</b>
19a. DATE OF OPERATION <b>none</b>		19b. MAJOR FINDINGS OF OPERATION <b>none</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>none</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>no injury</b>
22. I hereby certify that I attended the deceased from <b>Dec 23, 1948</b> to <b>Jan 1, 1949</b> , that I last saw the deceased alive on <b>Jan 1, 1949</b> , and that death occurred at <b>8:37 p.m.</b> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <b>Robert G. Warner MD</b>		23b. ADDRESS <b>Paul Brown Co. Overland</b>		23c. DATE SIGNED <b>Jan 3 49</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>1-4-48</b>		24c. NAME OF CEMETERY OR CREMATORY <b>ST MARY'S Cem.</b>
24d. LOCATION (City, town, or county) (State) <b>BRIDGETON MO</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>ORTMANN FUNERAL HOME Overland MO</b>		
DATE RECEIVED BY LOCAL REGISTRAR'S SIGNATURE <b>JAN 3 1949</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>ORTMANN FUNERAL HOME Overland MO</b>		

(Licensed Embalmer's Statement on Reverse Side)

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

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**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 \_\_\_\_\_

..... Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Al C. Ortman .....

Licensed Embalmer No. 3478 .....

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.