

FILED DEC 1 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38671

State File No. ....

318

1003

9809

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).<br>a. STATE <u>Missouri</u><br>b. COUNTY <u>W</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>St. Louis</u> | c. LENGTH OF STAY (in this place)<br><u>LIFE</u> | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>St. Louis</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Anthony Hospital</u>                              |  | d. STREET ADDRESS (If rural, give location)<br><u>18 4232 Swan Avenue</u>  |  |

|   |                           |   |   |
|---|---------------------------|---|---|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>Baby Twin #2</u><br>b. (Middle) _____<br>c. (Last) <u>Dunn</u> |                           | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Nov 7 - 49</u>      |   |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>✓</u> | 8. DATE OF BIRTH <u>Nov-7-49</u>                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                         |                           | 10b. KIND OF BUSINESS OR INDUSTRY                               | 11. BIRTHPLACE (State or foreign country) <u>St. Louis Missouri</u> |
|   |                           |   | 12. CITIZEN OF WHAT COUNTRY?  |

|                                       |  |                             |
|---------------------------------------|--|-----------------------------|
| 13a. FATHER'S NAME <u>Lester Dunn</u> | 13b. MOTHER'S MAIDEN NAME <u>Beenetta Grubbs</u> | 14. NAME OF HUSBAND OR WIFE |
|---------------------------------------|--|-----------------------------|

|  |                         |  |                              |
|--|-------------------------|--|------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME <u>Lester Dunn</u> | ADDRESS <u>4232 Swan Ave</u> |
|--|-------------------------|--|------------------------------|

|   |   |  |                                  |
|---|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure; asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>   |  |                                  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br>DUE TO (c) _____ |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |                                  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|----------------------------------|--|

|   |  |  |
|---|--|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)        | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>159</u> |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>776X</u>                     |

22. I hereby certify that I attended the deceased from Nov 7, 1949 to Nov 7, 1949, that I last saw the deceased alive on Nov 7, 1949, and that death occurred at 3:00 p.m., from the causes and on the date stated above.

|   |                              |                                 |
|---|------------------------------|---------------------------------|
| 23a. SIGNATURE <u>H. G. Mason</u> (Degree or title) | 23b. ADDRESS <u>77-58-18</u> | 23c. DATE SIGNED <u>11/7/49</u> |
|---|------------------------------|---------------------------------|

|   |                          |  |   |
|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>11-8-49</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u> |
|---|--------------------------|--|---|

|   |  |  |                               |
|---|--|--|-------------------------------|
| DATE REC'D BY LOCAL REG. <u>NOV 14 1949</u> | REGISTRAR'S SIGNATURE <u>J. B. Lusater</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>A W McLaughlin</u> | ADDRESS <u>2301 Lafayette</u> |
|---|--|--|-------------------------------|

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

6086

**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 C. W. Cooper

Licensed Embalmer No. 2830

P. O. Address 2301 Lafayette

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.