

FILED JUL 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25780  
Registrar's No. 1540

BIRTH NO. 49878-54 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>2129</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Normandy</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (in this place) <b>6 1/2 hrs</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Normandy Osteopathic Hosp.</b>		e. STREET ADDRESS (If rural, give location) <b>5170 Cabanne Avenue</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>DONALD</b>	b. (Middle) <b>LEE</b>	c. (Last) <b>DUNN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 29, 1954</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>June 29, 1954</b>	9. AGE (In years last birthday) <b>0</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 12 HRS. Days <b>0</b>	IF UNDER 12 HRS. Hours <b>6</b>	IF UNDER 12 HRS. Min. <b>15</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Normandy, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Donald Dunn</b>	13b. MOTHER'S MAIDEN NAME <b>Rosalie Loberg</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Donald Dunn</b>	ADDRESS <b>Cape Girardeau, Mo.</b>
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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		INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Respiratory Failure</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Bilateral Atelectasis</b> DUE TO (c) <b>Prematurity</b>		
II. OTHER SIGNIFICANT CONDITIONS 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? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) <b>Normandy St. Louis Mo.</b>
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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?
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22. I hereby certify that I attended the deceased from **6/29/54**, 19**54**, to **6/29/54**, 19**54**, that I last saw the deceased alive on **6/29/54**, 19**54**, and that death occurred at **5:12 P.** m., from the causes and on the date stated above.

23a. SIGNATURE (In ink or title) <b>Mark Blaylock</b>	23b. ADDRESS <b>5301 St. Louis Avenue</b>	23c. DATE SIGNED <b>6/29/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>6-30-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Concordia Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>6/30/54</b>	REGISTRAR'S SIGNATURE <b>Herbert S. Stomberg</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>WHITE CHAPEL</b>	ADDRESS <b>FERGUSON, MO.</b>
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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..

NOT EMBALMED

Student.....  
Signature of Student Embalmer

Signed.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.