No. 300
10-48

FILED NOV 30 1954

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36706

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 320

0

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

1. PLACE OF DEATH
a. COUNTY: Callaway
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fulton
c. LENGTH OF STAY (in this place): 4 years 5 m
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital No 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Lafayette
c. CITY OR TOWN: Lexington
d. Is Residence within limits of a city or incorporated town? Yes ☒ No ☐
e. STREET ADDRESS (If rural, give location): 0542

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle):
c. (Last): Dunker

4. DATE OF DEATH (Month) (Day) (Year): 11 - 18 - 54

5. SEX: M
6. COLOR OR RACE: WH
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 3-19-22
9. AGE (In years last birthday): 32
IF UNDER 1 YEAR: Months 5 Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?
10b. KIND OF BUSINESS OR INDUSTRY: ?
11. BIRTHPLACE (City and State or Foreign Country): Lexington, Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: John Dunker
13b. MOTHER'S MAIDEN NAME: Mary DK
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): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: James Dunker
ADDRESS: Box 23 Oro Grande Cal

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Status Epilepticus

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
3532
20. AUTOPSY? YES ☐ NO ☐

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1954, *to* 18-Th Nov 1954, *that I last saw the deceased alive on* 11-17, 1954, *and that death occurred at* 8:15 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R P Price Mr B Lafayette Jamaica
23b. ADDRESS: Fulton, Mo
23c. DATE SIGNED: 11-18-54

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 11-23-54
24c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
24d. LOCATION (City, town, or county) (State): Columbia Mo

DATE REC'D BY LOCAL REG.: Nov. 23-1954
REGISTRAR'S SIGNATURE: Maretta Lawrence 426-0
25. FUNERAL DIRECTOR'S SIGNATURE: J. O. Roberts
ADDRESS: Columbia Mo

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

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. (Fa
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.