No. 300
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FILED APR 11 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8710

BIRTH NO. _____ REG. DIST. NO. 178 PRIMARY REG. DIST. NO. 5666 Registrar's No. 21

1. PLACE OF DEATH
a. COUNTY: LEWIS
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL UNION
c. LENGTH OF STAY (In this place): XXXXXX
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): XXXXXXXXXXXXXXX

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: LEWIS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL UNION 0560
d. STREET ADDRESS (If rural, give location): 1½ mi. SE MAYWOOD, MO.

3. NAME OF DECEASED (Type or Print)
a. (First): MARION
b. (Middle): ELMORE
c. (Last): NUNN

4. DATE OF DEATH (Month) (Day) (Year): MARCH 30, 1955

5. SEX: MALE 0
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 7/10/81
9. AGE (In years last birthday): 73 — If under 1 year: Months 8, Days 20 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (City and State or Foreign Country): LEWIS COUNTY, MISSOURI
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: MARION NUNN
13b. MOTHER'S MAIDEN NAME: MARY SCHULTZ
14. NAME OF HUSBAND OR WIFE: LULU NUNN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): XXXXXXX
16. SOCIAL SECURITY NO.: 355-01-9666
17. INFORMANT'S SIGNATURE OR NAME: LULU NUNN — ADDRESS: MAYWOOD, MO.

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) CORONARY HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH

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.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 4201
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* 2/5, 1955, *to* 3/30, 1955, *that I last saw the deceased alive on* 3/30, 1955; *and that death occurred at* 1:00 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. L. Ellery (Degree or title) MD
23b. ADDRESS: Lebanon Mo
23c. DATE SIGNED: 4/2/55

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 4/2/55
24c. NAME OF CEMETERY OR CREMATORY: MAYWOOD
24d. LOCATION (City, town, or county) (State): MAYWOOD, MO.

DATE REC'D BY LOCAL REG.: 4/4/55
REGISTRAR'S SIGNATURE: P. W. Jennings, M.D. 161-0 E.L.
25. FUNERAL DIRECTOR'S SIGNATURE: Charles L. Arnold
ADDRESS: Lewistown, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

_____, Student Embalmer No. _____,

working under my personal supervision.

Student _____
Student Embalmer

Signed Charles L. Arnold Jr.

Licensed Embalmer No. 4667

P. O. Address LEWISTOWN, MO.

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.