

UNITED STATES DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 15 1960

-60-027476

STATE FILE NUMBER

Registration District No. 171 Primary Registration District No. 3035 Registrar's No. 707

ENDED

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Lexington</u>		Length of stay in 1b <u>50 yr.</u>	c. CITY OR TOWN <u>Lexington</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lexington Memorial Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1602 Oneida</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>KATHLEEN</u> Middle <u>MARTHA</u> Last <u>DUNFORD</u>			4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1960</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. <u>November</u> <u>17, 1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>Afghanistan, India</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Christopher Johnstone</u>	13b. MOTHER'S MAIDEN NAME <u>Kathleen Dunlop</u>	14. NAME OF HUSBAND OR WIFE <u>W.A. Dunford (Dec)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Dallas C. Buck Lexington, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Severe hypertension. Arteriosclerotic</u>	
DUE TO (c) <u>heart disease</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <u>7-16-60</u> to <u>7/24/60</u> and last saw her alive on <u>7/24/60</u> Death occurred at <u>5:20 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deputy or title) <u>Ben H. Brasher</u>	22b. ADDRESS <u>M.D. Lexington, Mo</u>	22c. DATE SIGNED <u>7/25/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/27/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Machpelah Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lexington, Mo.</u>
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24. FUNERAL DIRECTOR <u>Vaughn-Walker</u>	ADDRESS <u>Lexington, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-1-60</u>	26. REGISTRAR'S SIGNATURE <u>Marion E. ...</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____
Signature of Student Embalmer

Signed W. R. Vaughn

Licensed Embalmer No. 4023

P. O. Address Springton

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.