

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026373  
STATE FILE NUMBER

AMENDED **F** Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 159

FILED JUL 10 1961

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in 1b <u>2 DAYS</u>	c. CITY OR TOWN <u>St. Charles</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1900 W. Clay</u>
3. NAME OF DECEASED (Type or print) First <u>Darrel</u> Middle <u>Shayne</u> Last <u>Dunagan</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-30-61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months _____ Days _____ Hours <u>53</u> Min. <u>20</u>
11. BIRTHPLACE (City and state or country) <u>St. Charles, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Howard Dunagan</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Bob Hooten</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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>Mary Hooten Dunagan - 1900 W. Clay</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra cranial Hemorrhage.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>53 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 type="checkbox"/> No <input type="checkbox"/> Unknown
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
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
21. I attended the deceased from <u>June 30</u> to <u>July 2</u> and last saw her/him alive on <u>July 2</u> Death occurred at <u>3:50 PM July 2, 1961</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>R. E. Hammes M.D.</u>		22b. ADDRESS <u>707 N. 5th St. Charles.</u>	22c. DATE SIGNED <u>7-2-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JULY 3, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>oak grove cem.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. CHARLES Mo</u>
24. FUNERAL DIRECTOR <u>C. L. PRINSTER.</u>	ADDRESS <u>ST. CHARLES, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>July 3-61</u>	26. REGISTRAR'S SIGNATURE <u>Mirella Wilson</u>

JUL 11 1961

**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. *Body not embalmed*

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *E. L. Prinster* \_\_\_\_\_

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.