

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-006000

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 129 Primary Registration District No. 200 Registrar's No. 220

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield,		c. CITY OR TOWN Springfield	
Length of stay in 1b 12 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If outside, give location) 1819 W. Lee	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last SARAH M. DUNLAP			4. DATE OF DEATH Month Day Year February 18, 1963		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH November 19, 1874	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months Days Hours Min. 2 29
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY In Home		11. BIRTHPLACE (City and state or country) Carroll County, Arkansas	
12. CITIZEN OF WHAT COUNTRY USA					

13a. FATHER'S NAME Henry Walden		13b. MOTHER'S MAIDEN NAME Martha Johnston		14. NAME OF HUSBAND OR WIFE James T. Dunlap	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None			16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Martha Klann Springfield, Mo.

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure		INTERVAL BETWEEN ONSET AND DEATH 2 years
DUE TO (b) Arteriosclerotic Vascular disease		
DUE TO (c) Unknown		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Occlusive peripheral vascular disease		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	
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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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Springfield Greene, Mo.	20f. CITY, TOWN, OR LOCATION Springfield Greene, Mo.	20g. COUNTY Greene	20h. STATE Mo.
21. I attended the deceased from Feb 26 '54 , to Feb 18 '63 and last saw her alive on Feb 17 '63 Death occurred at 1:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>[Signature]</i>	(Degree or title)	22b. ADDRESS 609 Cherry	22c. DATE SIGNED Feb 19 '63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 20, 1963	23c. NAME OF CEMETERY OR CREMATORY Eastlawn	23d. LOCATION (City, town, or county) (State) Springfield, Missouri
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24. FUNERAL DIRECTOR Gorman-Scharpf Funeral Home, Inc. Springfield, Missouri	25. DATE RECD. BY LOCAL REG. 2-19-63	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
ITEM NO. SHOULD READ
BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

Permit 2-28-63

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 Lewis G. Scherff

Licensed Embalmer No. 3802

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