

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

5 1929

17914

1. PLACE OF DEATH

County Henry Registration District No. 349
Township Deer Creek Primary Registration District No. 5499
City No. _____ St. _____ Ward _____

File No. _____
Registered No. 10
St. _____ Ward _____

2. FULL NAME

Mrs Hallie Duffey

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John B. Duffey

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 28, 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
61 0 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

Bunceton, Missouri

10. NAME OF FATHER

Samuel Schrouf

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Kentucky

12. MAIDEN NAME OF MOTHER

Callie Brooks

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Kentucky

14. INFORMANT

Mrs. Doris Datweiler
(Address) Clinton, Mo.

15. FILED

May 15, 1929 Mrs. A. A. Gray dpt. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 23, 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar. 10, 1929 to May 23, 1929 that I last saw her... alive on May 23, 1929 and that death occurred, on the date stated above, at 11 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Secondary Carcinoma of the liver and axillary glands left.

Diabetes (duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

440 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) E. E. O'Connell, M. D.

, 19 (Address) Clinton Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Englewood Cemetery May 24, 1929

20. UNDERTAKER ADDRESS Spore & Son Clinton Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PARENTS

THIS IS A PERMANENT RECORD

Ed. C. Taylor
Clinton, Mo.

cated by check marks, lacking from the death certificate:

Name: Mrs. Hallie Duffey

Who died at: Henry Co. on May 23, 1939.

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Secondary carcinoma of the liver and axillary glands left

Contributory: Diabetes Primary of left Breast

Where was disease contracted? _____

Did operation precede death? _____ Date of _____

Was there an autopsy? _____ What test confirmed diagnosis? _____

Name of physician: Ed. C. Peeler

Address of physician: Clinton, Mo.

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH *Henry*
 County *Deer Creek* Registration District No. *349* File No.
 Township *Deer Creek* Primary Registration District No. *3499* Registered No. *10*
 City (No.) St. Ward)

2. FULL NAME *Mrs. Halley Duffey*
 (a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>John B. Duffey</i>			
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>April 28-1868</i>			
7. AGE	YEARS <i>61</i>	MONTHS <i>X</i>	DAYS <i>25-</i>
	If LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Housewife</i> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer			
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Puncheon Mo.</i>			
PARENTS	10. NAME OF FATHER <i>Samuel Shrou</i>		
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Kentucky</i>		
	12. MAIDEN NAME OF MOTHER <i>Gladie Brooks</i>		
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Kentucky</i>		
14. INFORMANT <i>Mrs. Davis Daturelle</i> (Address) <i>Clinton Mo.</i>			
15. FILED <i>May 25 1929</i> <i>Mrs. A. G. Gray, Dir.</i> REGISTRAR			

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 23 1929*

17. I HEREBY CERTIFY That I attended deceased from *May 10 - 1929* to *May 23 1929* that I last saw him *all on* *May 23 - 1929*, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Secondary Carcinoma of the liver and Auxillary glands
Primary cancer of dist
pancreas (duration) 10 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) *Diabetes* (duration) *10 yrs. mos. ds.*

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? *No.* DATE OF.....
 WAS THERE AN AUTOPSY? *No.*
 WHAT TEST CONFIRMED DIAGNOSIS *Clinical*
 (Signed) *Dr. Peeler* M. D.
 , 19 (Address) *Clinton Mo*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Englewood Cemetery* DATE OF BURIAL *May 24 1929*
 20. UNDERTAKER ADDRESS

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.
 AGE should be carefully supplied. AGE should be carefully supplied. AGE should be carefully supplied.
 PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.
 REGISTRATION SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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