

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

Do not use this space.

18279

**1. PLACE OF DEATH**

County Saline  
Township Slater Mo  
City Slater Mo (No. ....)

Registration District No. 999  
Primary Registration District No. 4479

File No. ....  
Registered No. 2932  
St. .... Ward)

**2. FULL NAME**

Hannah Jane Duncan

(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) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 1-1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
74 1 12

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work House wife  
(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) Gilman & Saline Co Mo.

10. NAME OF FATHER John E. Johnson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Gilman & Saline Co Mo.

12. MAIDEN NAME OF MOTHER Elvira Murphy

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Detroit Michigan

14. INFORMANT (Address) Mrs. E. E. Ordea Slater Mo.

15. FILED 5-14-30 W. M. Tuttle REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 13 1930

17. I HEREBY CERTIFY, That I attended deceased from 5-12 1930, to 5-13 1930, and that I last saw her alive on May 11 1930, and that death occurred, on the date stated above, at 11:30 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Influenza  
IIA  
1010 B

(duration) 1 yrs. 7 mos. 7 ds.  
CONTRIBUTORY Bronch. Bronch. to  
(SECONDARY)

(duration) 10 yrs. 1 mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED HO  
IF NOT A PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical  
(Signed) J. D. Davidson M. D.

\*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  
Fish Creek near Gilman 5-14-1930

20. UNDERTAKER ADDRESS  
Jones & Sage Slater 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.

WHITE FORM NO. 1, WITH CHANGING INSTRUCTIONS—THIS IS A PERMANENT RECORD

99  
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