

MAY 20 1937 MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. 16372  
Township \_\_\_\_\_ Primary Registration District No. 2001 Registered No. 0349  
City Springfield, Mo. (No. St. Johns Hosp.) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME A. J. Duncan

(a) Residence, No. Mt. View, Mo. St. \_\_\_\_\_ Ward Mt View Mo  
(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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 10 - 1873  
7. AGE YEARS 63 MONTHS 4 DAYS 14 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/24 1937

22. I HEREBY CERTIFY, That I attended deceased from Apr 20, 1937, to Apr 24, 1937.  
I last saw him alive on Apr 24, 1937. Death is said to have occurred on the date stated above, at 7 A. m.

The principal cause of death and related causes of importance were as follows:

Cerebral Thrombus or Embolus Date of onset \_\_\_\_\_  
920  
Other contributory causes of importance: Endocarditis chronic

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo  
13. NAME William Duncan  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill  
15. MAIDEN NAME Rulinda Henderson  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo  
17. INFORMANT John Duncan (ADDRESS) Mt View Mo  
18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. View, Mo. DATE 4/25/37

Name of operation None Date of \_\_\_\_\_  
What test confirmed diagnosis? Neurological Exam

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_

(Signed) J. C. Terrell, M. D.  
(Address) Springfield Mo.

19. UNDERTAKER Herman Lohmeyer Funeral Home (ADDRESS) Springfield, Mo.

20. FILED Apr 25 1937 Chas. D. George Registrar

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.

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**1. PLACE OF DEATH**

County Greene

Registration District No. 318

File No. 16372

Township Springfield

Primary Registration District No. 2001

Registered No. 0349

City Springfield (No.         )

St.          Ward         

**2. FULL NAME**

(a) Residence, No.          St.          Ward.         

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, .....hrs. or .....min.
	<u>63</u>	<u>4</u>	<u>4</u>	

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....	11. Total time (years) spent in this occupation.....
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....	
	10. Date deceased last worked at this occupation (month and year).....	

12. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE          DATE          19         

19. UNDERTAKER (ADDRESS)

20. FILED Aug 4 1937 Chas A. George Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/24 1937

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

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

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) T. E. Fargogh, M. D.

(Address) Springfield Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

5-16372