

REC'D SEP 28 1938

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

30149  
Do not use this space.

1. PLACE OF DEATH  
(a) County Stoddard Registration District No. 837  
(b) Township Castro Primary Registration District No. 6099 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.  
2. PRINT FULL NAME Ruth Duffey 157  
(a) Residence, No. Avert mo. St.  (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBANDS OF (OR) WIFE OF Raymond Duffey  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
21 2 6  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Nursewife  
9. Industry or business in which work was done, as 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) Aug. 4 193822. I HEREBY CERTIFY that I attended deceased from Unattended 1938 to 1938, 1938I last saw h. alive on \_\_\_\_\_, 1938. Death is said to have occurred on the date stated above, at 11a.m.

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

Since birth of child July 1, 1938  
Heart failure  
Date of onset D.R.

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1938Where 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) John W. Williams M. D.  
(Address) St. Louis, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cape County, Missouri  
13. NAME John W. Williams  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pike County, Indiana  
15. MAIDEN NAME Nancy Carlton  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cape County, Missouri  
17. INFORMANT (ADDRESS) Raymond Duffey, Avert, Missouri  
18. BURIAL, CREMATION, OR REMOVAL PLACE Fairview, Mo. DATE Aug 7, 1938  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Lloyd M. Mergel, Advance, Mo.  
20. FILED Aug 31, 1938 Dr. C. W. Ford Local Registrar.

2000

**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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

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 this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Stoddard Registration District No. 837  
(b) Township Castor Primary Registration District No. 6099 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Ruth Duffey

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

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) May 30 1917

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
21 2 06

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

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Oct. 8 1938 Loonid Punch Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 6 1938

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) John Wilage Loonid Punch

(Address) Bloomfield mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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(a) County Stoddard Registration District No. 837  
(b) Township Castor Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 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.  
21 2 6

OCCUPATION

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

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

FATHER MOTHER

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 6 1938

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:

since birth of child July 1938 Date of onset

Heart failure 200W

Other contributory causes of importance: Seen only after death in hospital had determined with out autopsy.

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? 76

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) John Wilson Co. S. & B.

(Address) Bloomfield M.W.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.