

REC'D FEB 21 1939

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

2565

Do not use this space.

## PLACE OF DEATH

(a) County Jackson Registration District No. 403  
(b) Township Brookings Primary Registration District No. 4238 Registered No. \_\_\_\_\_  
(c) City Raytown (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 Miss Hattie M. Duncan

(a) Residence, No. Raytown 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 20 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... mln.  
65 6 29

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. Domestic  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dearborn Mo.13. NAME Edward Willis Duncan14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia15. MAIDEN NAME Lavinia E. Duncan16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia17. INFORMANT (ADDRESS) Mrs. A. F. Hall  
Raytown, Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Camden Point, Mo. DATE Jan 20, 193919. FUNERAL DIRECTOR (NAME) (ADDRESS) E. Clark Beget  
Raytown, Mo.20. FILED 1-19 1939 McEubank Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-19 1939

22. I HEREBY CERTIFY, That I attended deceased from July 1937, to Jan 19 1939  
I last saw him alive on Jan 18 1939. Death is said to have occurred on the date stated above, at 5:30 A. M.  
The principal cause of death and related causes of importance were as follows:

Pulmonary Abscess ✓Date of onset  
1-10-30

Other contributory causes of importance:

Arterio sclerosis  
Chr. Myocarditis1-1-29  
2-5-34Name of operation None 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) McEubank, M. D.  
(Address) Raytown, Mo.

92c

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**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.**

RECEIVED BY THE BOARD OF HEALTH

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

25-65-  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 403  
(b) Township Raytown Primary Registration District No. 4238  
(c) City Raytown (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. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Hattie M. Duncan

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-19-39

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

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

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the \_\_\_\_\_ stated above, at \_\_\_\_\_ m. The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
65 6 29

Date of onset 1931

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 \_\_\_\_\_

Pulmonary abscess  
Tuberculosis  
72  
72

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

Other contributory causes of importance:  
Arterio sclerosis  
Chr. myo Carditis

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 1-20 1939 D. M. Gubank Local Registrar

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) D. M. Gubank M. D.  
(Address) Raytown Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important.

S-2565