

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.

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

7695
Do not use this space.

MAR 23 1939

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 773
 (b) Township St. Francois Primary Registration District No. 6018A
 (c) City Farmington, Mo. (d) Street No. State Hospital No. 4 Registered No. 21
 (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 SIMON DUVAL

(a) Residence, No. Perry County, Mo. 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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-18-39 Unknown

7. AGE YEARS 65 MONTHS Un.? DAYS ? Un. If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
 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) Missouri

FATHER 13. NAME William Duvall

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT Records of State Hospital No. 4
 (ADDRESS) Farmington, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE State Hospt. #4 CEMETERY 2-20 DATE 1939

19. FUNERAL DIRECTOR (NAME) CHAS. RICHARDSON
 (ADDRESS) Farmington, Mo.

20. FILED Feb 18, 1939 T. J. Roberson
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-18-39, 19...

22. I HEREBY CERTIFY, That I attended deceased from 1-7, 1939, to 2-18-39, 19...
 I last saw him alive on 2-17, 1939. Death is said to have occurred on the date stated above, at 3:25a m.
 The principal cause of death and related causes of importance were as follows:

Psychosis with cerebral arteriosclerosis

Date of onset Unknown

Other contributory causes of importance:

Atrophic rhinitis.
General arteriosclerosis.
Chronic bronchitis.

Unknown
Unknown
Unknown

Name of operation None Date of No
 What test confirmed diagnosis? Clin. & Lab Was there an autopsy? No

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 None
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify Removal of tonsils
 (Signed) Chas. G. Fivis Graves M. D.
Farmington, Mo.

(Address) 180

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

Chas. Richardson

Licensed Embalmer No.

3167

P. O. Address

Farmington

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.