

JAN 17 1940

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

44840
Do not use this space.

1. PLACE OF DEATH ²
 (a) County Shelby Registration District No. 831
 (b) Township Black Creek Primary Registration District No. 6692
 (c) City _____ (d) Street No. _____
 (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 Mary Catharine McDuffee
 (a) Residence, No. _____ St. 1
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 15, 1855
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
84 7 27
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeping
 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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec-12-1939
 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1939 to Dec 12, 1939
 I last saw her alive on Dec 8, 1939 Death is said to have occurred on the date stated above, at 8:30 p. m.
 The principal cause of death and related causes of importance were as follows:
Myocardia unknown
 Date of onset _____
 Other contributory causes of importance: 93A
 Name of operation None Date of _____
 What test confirmed diagnosis? Blind 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 _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) H. D. Stephens, M. D.
 (Address) Shelbyville, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Co. Mo.
 FATHER
 13. NAME Alexander Mc Duffee
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No. Carolina
 MOTHER
 15. MAIDEN NAME Rebecca Collett
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va.
 17. INFORMANT (ADDRESS) Albert B. McDuffee
Shelbyville, Mo.
 18. BURIAL, CREMATION, OR REMOVAL Shelby Cemetery
Shelbyville, Mo. DATE Dec 14, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. P. Thompson
Shelbyville, Mo.
 20. FILED Dec 13, 1939 Paul Goe
Local Registrar.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

I X 10805

RECEIVED

District Health Officer No. 10

District File Number 1-40-190

Date Filed JAN 16 1940

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 E. Thompson

Licensed Embalmer No. 1632

P. O. Address Shelbyville, Va.

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.