No. 2

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 12 1940

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

State File No. 10290

Registrar's No. 371

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: (Specify whether)

In this community: 8 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Buchanan

(c) City or town: St. Joseph (If outside city or town limits write "RURAL")

(d) Street No.: 10th & Bell Sts
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years

3. (a) PRINT FULL NAME: 525 Mossie Mae Duncan

3. (b) If veteran, name war: no

3. (c) Social Security No.: no

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: Edward

6. (c) Age of husband or wife if alive: 31 years

7. Birth date of deceased: July 29, 1909
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
30	8	2	hr. ____ min.

9. Birthplace: Richmond (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: housewife

11. Industry or business:

MOTHER FATHER

12. Name: Jerry Cox

13. Birthplace: Missouri (City, town, or county) (State or foreign country)

14. Maiden name: Cordelia Neil

15. Birthplace: Missouri (City, town, or county) (State or foreign country)

16. (a) Informant: Edward Duncan

(b) Address: 10th & Bell Sts

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 2-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Amazonia Cemetery

18. (a) Signature of funeral director: Tracy Barry Funeral Home

(b) Address: 218 South 10th St

19. (a) April 3-1940 (Date received local registrar) (b) H J Nettelhorst (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31 year 1940 hour 12 minute 35 AM.

21. I hereby certify that I attended the deceased from 3-26-40, 19__, to 3-31, 1940, that I last saw h. alive on 3-31, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Intestinal obstruction	
Due to: Intra-partum infection	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Pregnancy 7 mo. Dead foetus – 2-4 wks	

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work?

(e) Means of injury:

23. Signature: George W Tracy (M. D. or other)

Address: St Joseph Mo Date signed 4-1-40

(Licensed Embalmer's Statement on Reverse Side)

1452

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 Victor Barry, Registered Apprentice No. 252, working under my personal supervision.

Signed John E. Myers

Licensed Embalmer No. 3220

P. O. Address St. Joseph, Mo.

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.

V. S. No. 2B
10M—2-21-40
I X22659

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STANDARD CERTIFICATE OF DEATH

State File No. 10290

Registration District No. 85

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SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Missie May Duncan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 30 Months 8 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 5-29-40 (Date received local registrar) (b) H. J. Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 31 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction

Due to Intra Partum Infection

Due to

Other conditions Pregnancy 7 mo (Include pregnancy within 3 months of death)

Dead foetus 2 weeks

Major findings:
Of operations
Of autopsy 12-19

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Owen D. Craig (M. D. or other)
Address St Joseph Date signed

S-10290 1940