

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

16194

State File No. _____

Registration District No. 796

Primary Registration District No. 3038

Registrar's No. 58

1. PLACE OF DEATH:

(a) County Saline
 (b) City or town Marshall
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Blosser Home for Aged Women 3
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 years
 (Specify whether
 In this community 50 years
 years, months or days)

3. (a) PRINT FULL NAME Ida Duncan 525
 3. (b) If veteran, name war
 3. (c) Social Security No.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 20 1868
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 8 13 _____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER
 { 12. Name John Duncan
 { 13. Birthplace Dont Know
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Emily
 { 15. Birthplace Dont Know
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Fred. Gordon
 (b) Address Marshall, Mo.

17. (a) Burial (b) Date thereof April 5, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Ridge Park Cem.

18. (a) Signature of funeral director Campbell Russ
 (b) Address Marshall, Mo.

19. (a) 4-4-40 (b) Mary Kent
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline
 (c) City or town Marshall
 (If outside city or town limits, write "RURAL")
 (d) Street No. 840 East Fairwood
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3
 year 1940 hour 2 minute 0 P. M.
 21. I hereby certify that I attended the deceased from 1937
 _____, 19 _____, to April 3, 1940
 that I last saw her alive on April 3, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 4 yrs

Due to _____
 Due to _____ 93C

Other conditions Heart block 3 yrs
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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?
No
 (Specify type of place) (e) Means of injury _____

23. Signature W. P. Pitt (M. D. number) _____
 Address Marshall, Mo. Date signed 4-5-40

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.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 5-14-40

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.....

Joe N. Ruvio....., Registered Apprentice No.....
working under my personal supervision.

Signed Joe N. Ruvio
Licensed Embalmer No. 1171
P. O. Address Marshall 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.