

Registration District No.

Primary Registration District No.

JUL 15 1940

3038

89

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:
162 1/2 S. Jefferson St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 15 years
years, months or days)

3. (a) PRINT FULL NAME: Calvin Wade Durnil 654

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bertha Schafer 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan. 7, 1886
(Month) (Day) (Year)

8. AGE: Years 54 Months 4 Days 25 If less than one day
hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name Josiah Durnil13. Birthplace Unknown
(City, town, or county) (State or foreign country)14. Maiden name Polly Horton15. Birthplace Unknown
(City, town, or county) (State or foreign country)16. (a) Informant Bertha Durnil(b) Address 162 1/2 S. Jefferson17. (a) Burial (b) Date thereof May 4, 40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Ridge Park Cem.18. (a) Signature of funeral director Jessie Surme(b) Address W. Ashall19. (a) 6-3-40 (b) Mary Kent
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline

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

(d) Street No. 162 1/2 S. Jefferson
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2nd
year 1940 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from _____
to June 2nd, 1940

that I last saw him alive on June 1st
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Lung

Due to Don't Know

Due to 47

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations No Operation

Of autopsy No Autopsy

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?
712

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature W. A. Madison (M. D. or other)Address Marshall Mo. Date signed 6-3-40

Duration

Don't Know

Knows

PHYSICIAN

—

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 8,
District File Number 7-11-40
Date Filed

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 J. L. [Signature]
Licensed Embalmer No. 3235
P. O. Address W. [Signature]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22931**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **796**

Primary Registration District No. **3038**

Registrar's No. _____

1. PLACE OF BIRTH:

(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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Calvin Wade Durvill

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 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 **Jan 7 1886**
(Month) (Day) (Year)

8. AGE: Years **54 3/4** Months **4** Days **25**
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **8-76-'40** (b) **Mary Kent**
(Date received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH

Month **June** day **2**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) _____
(e) Means of injury _____

23. Signature **W. H. Jackson** (M. D. or other) _____

Address **Marshall Mo** Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-22931