

No. 2  
1-10-39  
-17-39  
X 21

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **39947**

Registration District No. **0098B**

Primary Registration District No. **0098B**

Registrar's No.

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

1. PLACE OF DEATH: **Stoddard**  
 (a) County: **Rural**  
 (b) City or town: **Rural**  
 (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 \_\_\_\_\_  
 In this community \_\_\_\_\_  
 (Specify whether years, months or days) **2**

3. (a) PRINT FULL NAME: **Lois Marie Duley**  
 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: **Aug. 31 1940**  
 (Month) (Day) (Year)

8. AGE: Years **0** Months **1** Days **18**  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace: **Stoddard Co., Missouri**  
 (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 { 12. Name: **Orville Duley**  
 { 13. Birthplace: **Illinois**  
 { 14. Maiden name: **Ruth Schaeffer**  
 { 15. Birthplace: **Illinois**  
 (City, town, or county) (State or foreign country)

16. (a) Informant: **Orville Duley**  
 (b) Address: **Dexter, Mo.**

17. (a) **Burial** (b) Date thereof: **10/20/40**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation: **Hagy Cem.**

18. (a) Signature of funeral director: **Blankenship-Strickland**  
 (b) Address: **Dexter, Mo.**

19. (a) **12/3 1940** (b) **Jennie Rector**  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State: **Missouri** (b) County: **Stoddard**  
 (c) City or town: **Rural**  
 (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

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **Oct.** day **19**  
 year **1940** hour **3** minute **0 P.M.**

21. I hereby certify that I attended the deceased from **Oct. 16th 1940** to **Oct. 19th 1940**  
 that I last saw her alive on **Oct. 19th 1940**  
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Bronchial Pneumonia**

Due to: **Weakened condition caused by Colitis.**

Due to \_\_\_\_\_  
 Other conditions: **11/12**  
 (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?  
**755**

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury: **320**

23. Signature: **J. Cannon** (M.-D. or other) **320**  
 Address: **Dexter** Date signed: **11/2/40**

RECEIVED

District Health Officer No. 2

District File Number 1240-176

Date Filed 12/9/40

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**