

No. 2
5-42
-17-39
X32875

46083

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 13 1944

Registration District No. _____

Primary Registration District No. 6782

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Rural - Miller

(b) City or town Osage - Jwhp
(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 Life - years, months or days _____ (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Miller

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

(d) Street No. Dixon, Mo R#3
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME JUDITH LYON DUNCAN

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 Married

6. (b) Name of husband or wife William Duncan 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased June 22 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>6</u>	<u>1</u>	_____ hr. _____ min.

9. Birthplace Dixon, Mo. R#3
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business Farm

12. Name Andrew Woody

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

14. Maiden name Louise Willis

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

16. (a) Informant Cliff Duncan

(b) Address Dixon, Mo. R#3

17. (a) Burial (b) Date thereof 12-26-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dixon, Mo. R#3

18. (a) Signature of funeral director L. B. Basy

(b) Address Osage Mo

19. (a) 12-26-43 (b) John H. Schuster
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23 year 1943 hour _____ minute 11 p. 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 Heart Failure
Did suddenly in Bed
Due to slightly after going to sleep

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

Major findings: _____
Of operations _____

Of autopsy no

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature L. B. Basy (M., D., or other) _____
Address Osage Mo Date signed 12-24-43

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

MOTHER FATHER

RECEIVED

Miller County Health Dep't

County File Number 44-4

Date Filed 1-7-44

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 Chasey
Licensed Embalmer No. 2694
P. O. Address Area 710

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan*
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County *Miller*
(b) City or town *Rural*
(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 _____ (Specify whether
years, months or days)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME *Justin L. Luncheon*
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month *July* Day *23*
Year *1963* Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____
_____ 19____

4. Sex *7* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *on*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive *69* Year _____
7. Birth date of deceased *June 22* (Month) (Day) (Year)

that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death *Heart failure*
which suddenly occurred after going to
sleep.
Due to *Myocarditis* _____ 19____
Due to _____

8. AGE: Years *68* Months *6* Days _____ If less than one day _____ min.
9. Birthplace _____ (City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____ (City, town, or county) (State or foreign country)
15. Birthplace _____ (City, town, or county) (State or foreign country)

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 _____

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) _____ (b) _____ (Date received local registrar) (Registrar's signature)

23. Signature *Of Bacey Carraway* (M. D. or other) _____
Address *Forre, Mo* Date signed *12/24/63*

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

SUPPLEMENTARY

MOTHER FATHER

Duration
2 yrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

5-43083