

FILED DEC 14 1944

Registration District No. **14 1944** Primary Registration District No. **5714**

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

1. PLACE OF DEATH

(a) County **McDonald**
(b) City or town **Lanagan Pinawit**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **None**
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **McDonald**
(c) City or town **Lanagan**
(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

Mary Thomas Duncan

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)
7. Birth date of deceased **Sept 11 1857**
(Month) (Day) (Year)

8. AGE: Years **87** Months **20** Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **MT Olive Ark**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER { 12. Name **John Bishop**
13. Birthplace **MT Olive Ark**
(City, town, or county) (State or foreign country)
14. Maiden name **Jones Hays**
15. Birthplace **MT Olive Ark**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edward Hooper**

(b) Address **Jayetteville Ark**

17. (a) **Removal** (b) Date thereof **10-1 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Jayetteville Ark**

18. (a) Signature of funeral director **M. Jones**

(b) Address **Jayetteville Ark**

19. (a) **Oct 5 1944** (b) **Ona Martin**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **1**
year **1944** hour **10** minute **30 P**.M.
21. I hereby certify that I attended the deceased from **June 25**
1944 to **Oct 1** 1944
that I last saw her alive on **Oct 1** 1944
and that death occurred on the date and hour stated above.

Immediate cause of death **Hepatic carcinoma 10 yrs**
Duration _____

Due to _____

Due to _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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. D. Fountain M.D.**
Address **Moell Mo** Date signed **10/16**

RECEIVED

District Health Officer No. 6,

District File Number 1244-1297

Date Filed DEC 7 1944

lawn

281

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, fact should be so stated above.

Items #3,12,13,14,15, amended by affidavit of granddaughter of Deceased 4-23-97

FILED DEC 14 1944

Registration District No.

Primary Registration District No. 5714

Registrar's No. 27

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Lauagan
(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) 7
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
in this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald
(c) City or town Lauagan
(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 Mary Thomas Bishop Hooper Duncan
FULL NAME Mary Thomas Bishop Hooper Duncan

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased Sept 11 1857
(Month) (Day) (Year)

8. AGE: Years 87 Months 20 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business William D. Bishop

12. Name William D. Bishop

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

14. Maiden name Hayes
(City, town, or county) (State or foreign country)

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

16. (a) Informant Edward Hooper

(b) Address Jayetteville Ark

17. (a) Removal (b) Date thereof 10-1-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jayetteville Ark

18. (a) Signature of funeral director M. D. ...

(b) Address Jayetteville Ark
19. (a) Oct 5 1944 (Date received from registrar)
W. D. ... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1
year 1944 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 25
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that I last saw her alive on Oct 1 1944
and that death occurred on the date and hour stated above.

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

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ADDITIONAL
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(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 M. D. ... (M.D. or other) _____

Address _____ Date signed Oct 16