

**FILED JAN 15 1945**

Registration District No. **31**

Primary Registration District No. **4040**

Registrar's No. **34**

**1. PLACE OF DEATH:**

(a) County **Benton mo**  
(b) City or town **Cole Camp mo**  
(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 **1**  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo** (b) County **Benton**  
(c) City or town **Cole Camp mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country **no**

3. (a) PRINT FULL NAME **DUNCAN JOSEPH MONROE**

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

4. Sex **M** 5. Color or race **W** 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 **Nov 18 1944**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**24** hr. min.

9. Birthplace **Sedalia mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business **semp**

12. Name **Byron L Duncan**

13. Birthplace **Liberia mo**  
(City, town, or county) (State or foreign country)

14. Maiden name **Elise Casey**

15. Birthplace **Liberia mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Byron L Duncan**

(b) Address **Cole Camp mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date of death **12-13-44**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Liberia mo**

18. (a) Signature of funeral director **E L Casey**

(b) Address **Liberia mo**

19. (a) **12/20/44** (Date received local registrar) (b) **Pauline Harvis** (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Dec**, day **13**, year **1944** hour **1** minute **25 P** M.

21. I hereby certify that I attended the deceased from **12-13-** 19**44** to **12-13-** 19**44**  
that I last saw him alive on **12-13-** 19**44**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to **83A**

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) (c) Means of injury

23. Signature **P. Reser** (M. D. or other) Address **Cole Camp mo** Date signed **12-13-44**

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

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

8000

1341

RECEIVED  
District Health Officer No. 7,  
District File Number 12-04-1532  
Date Filed 1-13-45

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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 W. Casey

Licensed Embalmer No. 2694

P. O. Address Berria, Md

**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.