

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 10920

FILED APR 23 1945  
Registration District No. 9314

Primary Registration District No. 6297  
Green Swamp no # listed  
Registrar's No.

1. PLACE OF DEATH:

(a) County Worth  
(b) City or town Rural Grant City Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: No  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution No (Specify whether)  
In this community Most of Life years, months or days

3. (a) PRINT FULL NAME

David Sherman Duley

3. (b) If veteran,

name war No

3. (c) Social Security

No No

4. Sex

M

5. Color or

race W

6. (a) Single, widowed, married,

divorced married

6. (b) Name of husband or wife

Martha A Morris

6. (c) Age of husband or wife if

alive 75 years

7. Birth date of deceased

Dec (Month)

18 (Day) - 1864 (Year)

8. AGE:

Years

Months

Days

If less than one day

80

2

13

✓ hr. ✓ min.

9. Birthplace

Locke Springs Mo  
(City, town, or county)

(State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

Farmer

12. Name

Thomas Duley

13. Birthplace

Uniontown - Ohio  
(City, town, or county)

(State or foreign country)

14. Maiden name

Mary Jane Deader

15. Birthplace

Uniontown Mo  
(City, town, or county)

(State or foreign country)

16. (a) Informant

Martha A Morris

(b) Address

Grant City Mo

17. (a)

Burial  
(Burial, cremation, or removal)

(b) Date thereof

March 3 - 1945  
(Month) (Day) (Year)

(c) Place: burial or cremation

Mt Vernon

18. (a) Signature of funeral director

John Andrews Jr

(b) Address

Grant City Mo

19. (a)

Mar 6 1945  
(Date received local registrar)

(b)

Mayne Ruchert  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. West of Grant City Mo  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1  
year 1945 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb  
15 to 3 1945;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral

hemorrhage Duration 5

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 83a  
(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 W. H. Ross (M.D. or other)

Address Grant City Mo Date signed 3-1-45

JAN 6 1948

---

---

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.....

*John Andrews Jr*....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*John Andrews Jr*  
Licensed Embalmer No. *4211*.....

P. O. Address..... *Grant City Mo*.....

**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.**