

S. No. 2
M-9-43
v. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13543

FILED APR 17 1945

Registration District No. Primary Registration District No. 5550 Registrar's No. 7

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

1. PLACE OF DEATH:

(a) County Nevada

(b) City or town Nevada, Mo. Canton
(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 4 months (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Billy Jean Duke

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

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

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

7. Birth date of deceased 10-4-44
(Month) (Day) (Year)

8. AGE: Years 4 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Nevada Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

12. Name Benton Duke

13. Birthplace Call Co. Okla
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Benton

15. Birthplace Nevada Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Margaret Duke

(b) Address Majors Mo

17. (a) 13 (b) Date thereof 2-15-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nevada

18. (a) Signature of funeral director [Signature]

(b) Address _____

19. (a) 3/10-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Nevada

(c) City or town Nevada - 41
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 14
year 1945 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from 2-13 1945 to 2-14 1945
that I last saw him alive on 2-14 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Unknown Duration _____

Due to _____

Due to _____

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

Major findings: Of operations 200

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 [Signature] (M. D. or other) _____

Address Viola Ark Date signed 2-26-45

112 F

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 5,

District File Number 448186

Date Filed 7-12-48

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.