

S. No. 2
8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36635

State File No. _____

FILED DEC 7 1945
Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1239

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Meth. Hosp. (1)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day (Specify whether
In this community 1 Day
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. Not stated
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Patricia Jeanette Duffy

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 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 July 2 1921
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
24 4 13 hr. min.

9. Birthplace Downs Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Reg. Nurse

11. Industry or business _____

12. Name Clarence E. Duffy

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

14. Maiden name Aucy Anne Brunnemer

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

16. (a) Informant C. E. Duffy

(b) Address Atchison Kans

17. (a) Removal (b) Date thereof 11-15-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Atchison Kans.

18. (a) Signature of funeral director Fleeman & Son Inc

(b) Address St Joseph, Mo.

19. (a) Nov 23-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

23. DATE OF DEATH: Month Nov day 15
year 1945 hour 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from 11-14-45
_____ 19____, to 11-15-45 19____;

that I last saw her alive on 11-15-45 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Laceration of brain

Duration
30 hrs

Due to auto accident

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

MOTHER FATHER

Major findings:
Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Accident

(b) Date of occurrence Nov. 14, 1945

(c) Where did injury occur? RFD Gower, Clinton, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
U.S. Highway #169
While at work? No. (Specify type of place) (e) Means of injury Auto Accident

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

Address St Joseph Mo Date signed 11-16-45

1428 (Licensed Embalmer's Statement on Reverse Side)

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

APR 7 1953

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..... *Robert H. Yapple*

Licensed Embalmer No. *3308*

P. O. Address..... *St. Joseph, 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.

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(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Mo. Meth. Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 da. (Specify whether
In this community 1 da. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(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 Patricia Jeanette Duffy

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 14
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____
to _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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 _____

7. Birth date of deceased July 2 1924
(Month) (Day) (Year)

8. AGE: Years 24 Months 4 Days 3
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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)

Due to _____

Due to _____

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

170-8-22

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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) accident

(b) Date of occurrence Nov 14 - 1945

(c) Where did injury occur? on highway in Buchanan County
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Collision between 2 cars

While at work? no (Specify type of place) (e) Means of injury _____

23. Signature Paul Furgraves (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

