

FILED JUL 16 1946

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 85

1. PLACE OF DEATH:

(a) County CLAY

(b) City or town EXCELSIOR SPRINGS  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
EXCELSIOR SPRINGS HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 MONTHS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

(c) City or town Kansas City  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME HENRIETTA T. DUNCAN

3. (b) If veteran, name war no

3. (c) Social Security No. 495-24-6400

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12<sup>th</sup>  
year 1946 hour 7:00 minute P. M.

21. I hereby certify that I attended the deceased from Coroner to DEAD 19\_\_\_\_; that I last saw him alive on 19\_\_\_\_; and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced DIVORCED

6. (c) Age of husband or wife if alive 3 years

7. Birth date of deceased: SEPT 6 1903  
(Month) (Day) (Year)

Immediate cause of death Suicide

Due to Car

Due to Car

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

8. AGE: Years 42 Months 9 Days 26  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation REGISTERED NURSE

11. Industry or business \_\_\_\_\_

12. Name WILLIAM TUBESING

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

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

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

16. (a) Informant MILDRED TUBESING

(b) Address COLE CAMP MO

17. (a) REMOVAL (b) Date thereof 7-2-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation COLE CAMP MO

18. (a) Signature of funeral director Jurgis Hopes

(b) Address Excelsior Springs MO

19. (a) 7/5/46 (b) Baroline Hutchings  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Suicide

(b) Date of occurrence July 12 1946

(c) Where did injury occur? Excelsior Springs Clay Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Place

While at work? yes (Specify type of place) \_\_\_\_\_ (e) Means of injury Car

23. Signature R. W. Crider (M.D. or other) Coroner  
Address Excelsior Springs Mo Date signed 7-2-46

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

Director Health Comm.

7-13<sup>2</sup> #6

REC'D

NOV 26 1945

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 James A. Moles

Licensed Embalmer No. 3296

P. O. Address Ex Springs 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 100

Reg  
July  
10 3 8 0 J

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 80 J

1. PLACE OF DEATH

(a) County Clay  
(b) City or town Excelsion Springs  
(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 \_\_\_\_\_ (Specify whether

In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Henrietta Duncan

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 div

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Sept 6 1903  
(Month) (Day) (Year)

8. AGE: Years 42 Months 9 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (State or foreign country)

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)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death suicide

33 Eds Chloride  
inhalation on a  
bus

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy 163912

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

**SUPPLEMENTARY**

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

21687

NOV 26 1944

23030