

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **8144**

BIRTH NO. **FILED MAR 23 1954** REG. DIST. NO. **96** PRIMARY REG. DIST. NO. **6290** Registrar's No. **18**

1. PLACE OF DEATH a. COUNTY <b>DALLAS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Minnesota</b> b. COUNTY <b>Moulton</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>BUFFALO R.R.</b>		c. CITY (If outside corporate limits, write RURAL) and give township) OR TOWN <b>Hayfield</b> <b>8220</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) **HATTIE** b. (Middle) **LIZZIE** c. (Last) **ROOT**

4. DATE OF DEATH (Month) (Day) (Year) **3-8-1954**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Widowed** 8. DATE OF BIRTH **2-14-1869** 9. AGE (In years last birthday) **85** IF UNDER 1 YEAR Months **0** Day **23** IF UNDER 2 HRS. Hours **0** Min. **23**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housekeeper** 10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Illinois** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **John W. Duffee** 13b. MOTHER'S MAIDEN NAME **Mary Wells** 14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT'S SIGNATURE OR NAME **Buf. Springs** ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Chronic Valvular heart disease & Chronic renal disease** (b) **Usual** (c) **Usual**

II. OTHER SIGNIFICANT CONDITIONS **Fractured hip bed sores** 2 yrs

INTERVAL BETWEEN ONSET AND DEATH **4 years**

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION **None** **4214 F** 20. AUTOPSY? YES  NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May**, 19**53**, to **March**, 19**54**, that I last saw the deceased alive on **3-8-54**, and that death occurred at **3:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **E. O. Plummer M.D.** 23b. ADDRESS **Buffalo, Mo.** 23c. DATE SIGNED **3-16-54**

24a. BURIAL, CREMATION, REMOVAL (Specify) **removal** 24b. DATE **3-9-1954** 24c. NAME OF CEMETERY OR CREMATORY **Fairview** 24d. LOCATION (City, town, or county) (State) **Hayfield Minn.**

DATE REC'D BY LOCAL REG. **3-18-54** REGISTRAR'S SIGNATURE **Grace Peters** 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **L. B. Jones Buffalo Mo.**

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10.48

300  
1

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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

*Morris B Jones*

Licensed Embalmer No. *4322*

P. O. Address *Buffalo, 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.