

health, Welfare public service
 300 -56
 diseases in Part I must be, causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

31419

STATE FILE NUMBER

FILED SEP 30 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 912

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>GREENE</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		a. STATE <u>Mo</u>		b. COUNTY <u>GREENE</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BURGE</u>		Length of stay in 1b <u>34 yrs</u>		c. CITY OR TOWN <u>SPRINGFIELD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
First <u>JOHN</u>		Middle <u>DEWEY</u>		Last <u>DUFFIE</u>		Month <u>9</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 19 1900</u>	
9. AGE (In years last birthday) <u>57</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIGHT-WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COOPER SUPPLY CO</u>		11. BIRTHPLACE (City and state or country) <u>LONGVIEW TEXAS</u>	
10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HILLARD DUFFIE</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no. of unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(?)</u>		17. INFORMANT <u>JAMES DUFFIE</u> Address <u>2126 N. NATIONAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral apoplexy</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>334x</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>July 16, 1957</u> to <u>Sept. 19, 1957</u> and last saw <u>her</u> alive on <u>Sept. 18, 1957</u> Death occurred at <u>8:30</u> <u>P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Leman D. Brown M.D.</u>				22b. ADDRESS <u>311 1/2 College</u>		22c. DATE SIGNED <u>9/21/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>9-25-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LINCOLN CEM</u>		23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD MO</u>	
24. FUNERAL DIRECTOR <u>H.Y. SMITH</u>		ADDRESS <u>602 N. JEFFERSON</u>		25. DATE RECD. BY LOCAL REG. <u>9-24-57</u>		26. REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	

(Licensed Embalmer's Statement on Reverse Side)

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
Signature of Student Embalmer

Signed *Herbert V. Smith*

Licensed Embalmer No. *42*

P. O. Address *Spring*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.