

pt. Health,  
, & Welfare  
SmPublic  
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S. 300  
ev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39382

XC-121 65 41  
D.O.A. FILED DEC 5 - 1957

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>BUTLER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		c. CITY OR TOWN <b>POPLAR BLUFF</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>112 S. Riverview Dr.</b>		Length of stay in lb <b>43 Years</b>	
d. STREET ADDRESS <b>112 S. RIVERVIEW DR.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>F.</b> Last <b>DUNCAN</b>			4. DATE OF DEATH <b>NOVEMBER 26, 1957</b>		
			Month Day Year		

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-16-89</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>STAVE</b>	11. BIRTHPLACE (City and state or country) <b>DEXTER, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>WILLIAM J. DUNCAN</b>	13b. MOTHER'S MAIDEN NAME <b>SARAH MABRY</b>	14. NAME OF HUSBAND OR WIFE <b>Not Applicable</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WWI</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>VA Hospital Records, Poplar Bluff, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 Minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE WITH LEFT CORONARY INSUFFICIENCY.</b>	<b>1 Year</b>
	DUE TO (c) <b>4201</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1. Chronic alcoholism. 2. Laennec's Cirrhosis (from Hospital records)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT <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
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21. <b>Viewed body on November 26, 1957</b>	
Death occurred at <b>3:00PM 11/26/57</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <b>Edward W. Cline, M.D.</b>	22b. ADDRESS	22c. DATE SIGNED <b>11/26/57</b>
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23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>11-29-57</b>	<b>Woodlawn</b>	<b>Poplar Bluff, Mo.</b>

24. FUNERAL DIRECTOR ADDRESS <b>Frank-Cotrell Poplar Bluff, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11/30/57</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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RECEIVED

DEC 2 1957  
BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

DEC 11 1957

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 *Fraunce M Hill*

Licensed Embalmer No. *2506*

P. O. Address *Poplar Bluff 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.