

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014160

STATE FILE NUMBER
1775

FILED APR 23 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1775

5. 300
1-57 V

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION WESTPORT NURSING 3940 MCGEE		d. STREET ADDRESS (If outside, give location) 4932 GARFIELD AVE	
3. NAME OF DECEASED (Type or print) First HENRY Middle EMILE Last DUVALL		4. DATE OF DEATH Month APRIL Day 6 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 17, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LETTER CARRIER		11. BIRTHPLACE (City and state or country) PORTAGE DES SIOUX, MO.	
13a. FATHER'S NAME JOSEPH NAPOLEON DUVALL		13b. MOTHER'S MAIDEN NAME MARIE LILLIAN KEENE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT MRS. A. T. POLLOCK	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial degeneration		INTERVAL BETWEEN ONSET AND DEATH about 5 years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) cause unknown		DUE TO (c) Had high tension & Homoplegia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 410x		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 Month, Day, Year 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 9-7-55 to 3-6-58 and last saw her/him alive on 3-6-58 Death occurred at 9:08 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James W. Graham M.D.		22b. ADDRESS 518 Argyle Bldg N.E. 9	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 4-7-58	
23c. NAME OF CEMETERY OR CREMATORY -		23d. LOCATION (City, town, or county) (State) VINITA, OKLAHOMA	
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS K.C., MO		25. DATE RECD. BY LOCAL REG. 4-7-58	
		26. REGISTRAR'S SIGNATURE Neave mindall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

James W. Graham

SEP 2 1958

100-50000

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 *Raymond M. Hardy*

Licensed Embalmer No. *4913*
P. O. Address *Indep 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.