

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032328
STATE FILE NUMBER

FILED SEP 22 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 862C

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Springfield</u> <u>0396</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Died in the Home</u>		Length of stay in 1b <u>1 Yr.</u>	d. STREET (If outside, give location) ADDRESS <u>1461 N. Missouri</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ezra</u> Middle <u>Eugene</u> Last <u>Duvall</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1958</u>	
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 17, 1886</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Elias Duvall</u>	13b. MOTHER'S MAIDEN NAME <u>Gennie Bush</u>	14. NAME OF HUSBAND OR WIFE <u>Lucy A Duvall</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>499-09-7245</u>	17. INFORMANT <u>Mrs. John Hill, Halfway, Mo.</u>
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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) <u>Broncho pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Paralysis of rt. side, result of CVA</u> DUE TO (c) <u>Essential Hypertension</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		<u>Unknown</u>

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 <u>2:30</u> Month <u>12</u> Day <u>57</u> Year <u>58</u> a.m. <u>p.m.</u>	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 <u>Springfield, Mo.</u>	COUNTY <u>Bolivar</u> STATE <u>Mo.</u>
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21. I attended the deceased from Death occurred at <u>2:30 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	and last saw <u>him</u> alive on <u>8-30-58</u>
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22a. SIGNATURE <u>Albert P. Simpson, M.D.</u> (Degree or title)	22b. ADDRESS <u>201 Springfield Med Bldg</u>	22c. DATE SIGNED <u>9-13-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 5, 58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bolivar City</u>	23d. LOCATION (City, town, or country) <u>Bolivar</u>	(State) <u>Mo.</u>
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24. FUNERAL DIRECTOR <u>Pitta Funeral Home</u>	ADDRESS <u>Bolivar, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-15-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *Sidney J. Pitts*

Licensed Embalmer No. *4939*

P. O. Address *Bolivar, m*

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.