

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004331
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 54

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Davies	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Altamont 6316
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1408 E. Harrison		Length of stay in 1b	d. STREET ADDRESS DK (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Evelena		First Duffey Middle	4. DATE OF DEATH Month Feb. Day 9 Year 1959
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1868
9. AGE (In years at birth) 90		IF UNDER 1 YEAR Months 11 Days 22	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Paysen, Ill , 1
13a. FATHER'S NAME William Poston		13b. MOTHER'S MAIDEN NAME Rebecca Alexander	14. NAME OF HUSBAND OR WIFE James Duffey, Decd.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address George Duffey-Kirksville, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility DUE TO (b) Pneumonia DUE TO (c) anhydremia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 2867			INTERVAL BETWEEN ONSET AND DEATH 2 yrs 3 mths
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 Jan-6-57 to Feb. 9-59 and last saw her alive on Feb. 3-59 Death occurred at 3:06 pm on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) R.O. Stickler MD		22b. ADDRESS Kirksville, Mo	22c. DATE SIGNED 2-9-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/11/59	23c. NAME OF CEMETERY OR CREMATORY Altamont Cemetery	23d. LOCATION (City, town, or county) Altamont, Mo. (State)
24. FUNERAL DIRECTOR Davis & Davis-Kirksville, Mo. ADDRESS		25. DATE RECD. BY LOCAL REG. 2-14-1959	26. REGISTRAR'S SIGNATURE Doris W. Ratliff

MEDICAL CERTIFICATION
All diseases in Part I must be causally related.
R.O. STICKLER, M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

6961 9 2 87

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 *Robert B. Harris*

Licensed Embalmer No. *4219*
P. O. Address *Kirkville, 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.