

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 28 1959

59-033263

STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 306

UNDECEASED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Pettis</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>Pettis</u>
Length of stay in 1b <u>10 yrs</u>		c. CITY OR TOWN <u>Sedalia</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>Bothwell Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>418 East 7th</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHRYN C. DUNCAN</u>			4. DATE OF DEATH Month Day Year <u>Sept 21 1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-1880</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Buffalo New York</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Butler</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Long</u>	14. NAME OF HUSBAND OR WIFE <u>Jeff. Duncan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mrs Joie Atkinson Sedalia</u>	

18. CAUSE OF DEATH (Enter only one cause per for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Rupture of Abdominal aorta</u>	DUE TO (b) <u>Arteriosclerosis</u>	<u>12 hours</u>
DUE TO (c)		<u>20 years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma of the cervix; Severe arthritis</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year	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 October 1957 to Sept. 21, 1959 and last saw her alive on September 21, 1959
 Death occurred at 5:29 P. M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Albert J. Campbell M.D.</u>	22b. ADDRESS <u>312 1/2 So. Ohio Sedalia Mo.</u>	22c. DATE SIGNED <u>9-21-59</u>
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-23-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>
23d. LOCATION (City, town, or county) <u>Sedalia</u>		(State) <u>Mo</u>

24. FUNERAL DIRECTOR ADDRESS <u>McLaughlin Bros. Sedalia</u>	25. DATE RECD. BY LOCAL REG. <u>9-22-1959</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

H. P. M. Crary

Licensed Embalmer No.

3153

P. O. Address

Sedalia

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.