

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39
1 X1931

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32938

Registration District No. 538

Primary Registration District No. 8028

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Madison Mo
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME JOHN F. DULLOY JR

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 5-7-1861 (Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace Madison Mo (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name William Duddy

13. Birthplace Madison Mo (City, town, or county) (State or foreign country)

14. Maiden name Margaret Magnus

15. Birthplace Madison Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature William Duddy

(b) Address Madison Mo

17. (a) Burial (b) Date thereof 9-1-39 (Month) (Day) (Year)

(c) Place: burial or cremation Madison Mo

18. (a) Signature of funeral director Thomas H. Brown

(b) Address Madison Mo

19. (a) Sept 1-1939 (b) S. C. S. Daugherty (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madison
(c) City or town Madison Mo (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30 year 1939 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Jan 1939, to Aug 30, 1939 that I last saw him alive on Aug 30 and that death occurred on the date and hour stated above.

Immediate cause of death Valvular heart lesion Duration 2 yrs

Due to Chronic bronchitis

Due to Arterio Sclerosis

Other conditions 92 W (Include pregnancy within 3 months of death)

Major findings: Of operations ✓

Of autopsy ✓

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ✓

(b) Date of occurrence ✓

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

While at work? _____ (Specify type of place) (e) Means of injury

23. Signature Therry Barton (M. D. or other)

Address Fordertown Mo Date signed 9/7/39

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Myron A. La Pee....., Registered Apprentice No.....
working under my personal supervision.

Signed *Myron A. La Pee*.....
Licensed Embalmer No. *4025*.....
P. O. Address *Fredricktown*.....

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 this body is not embalmed, above space should be left blank.