

FILED JUN 20 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

18122

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 4083

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Cass  
(b) City or town Cleveland mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 7 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass  
(c) City or town Cleveland,  
(If outside city or town limits, write "RURAL") 0  
(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 May day 18  
year 1940 hour 4 minute 15 P. M.

21. I hereby certify that I attended the deceased from May 17 1940 to May 18 1940  
that I last saw him alive on May 18 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Cerebral hemorrhage Duration 2 day

Due to Arteriosclerosis ?

Due to \_\_\_\_\_ ?

Other conditions Myocarditis ?  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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? 919  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature W A Moore (M. D. or other) \_\_\_\_\_  
Address Cleveland mo Date signed 5/19/40

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

3. (a) PRINT FULL NAME Jace Bates Duvall 140

3. (b) If veteran, name war NO 3. (c) Social Security No. 710

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

6. (b) Name of husband or wife Grace Duvall 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Nov 25 1879  
(Month) (Day) (Year)

8. AGE: Years 65 Months 5 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Richmond mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Ins. Agent

MOTHER FATHER { 12. Name Jae Duvall 9  
18. Birthplace un known (State or foreign country)

{ 14. Maiden name Wickman  
15. Birthplace un known (State or foreign country)

16. (a) Informant Grace Duvall  
(b) Address Cleveland and mo

17. (a) Burial (b) Date thereof May 19-40  
(Burial, cremation, or other) (Month) (Day) (Year)  
(c) Place: burial or cremation Cleveland Cemetery

18. (a) Signature of funeral director Geo. E. Myers  
(b) Address Cleveland mo

19. (a) May 19-40 (b) Geo E Myers  
(Date received local registrar) (Registrar's signature)

**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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

Licensed Embalmer No. ....

P. O. Address.....

**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.**