

FILED JAN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 229

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 39

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION Leons Nursing Home		d. STREET ADDRESS (If rural, give location) 938 E. Hyde Park Ave.	

3. NAME OF DECEASED (Type or Print) ISIDORA HARRIS DUNCAN			4. DATE OF DEATH Jan. 7, 1949		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH April 14, 1870		9. AGE (In years last birthday) 78		10. MONTHS 8 DAY 23	
11. BIRTHPLACE (State or foreign country) Adams County, Ohio		12. CITIZEN OF WHAT COUNTRY? U. S.			

13a. FATHER'S NAME William Harris		13b. MOTHER'S MAIDEN NAME Lucinda Rhoades		14. NAME OF HUSBAND OR WIFE A. C. Duncan	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Myrtle Weed, 805 E. Hyde Park Ave.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of bladder ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Remission				INTERVAL BETWEEN ONSET AND DEATH 4 mo. 5 yrs	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 1)	
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22. I hereby certify that I attended the deceased from Jan 1, 1948 to Jan 7, 1949, that I last saw the deceased alive on Jan 5, 1949, and that death occurred at 7:20 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. M. Jacobson		23b. ADDRESS 411 Kirkpatrick St.		23c. DATE SIGNED 1-8-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan. 9, 1949		24c. NAME OF CEMETERY OR CREMATORY Register Cemetery	
				24d. LOCATION (City, town, or county) (State) Buchanan County, Mo.	

DATE REC'D BY LOCAL REG. 1-14-49		REGISTRAR'S SIGNATURE E. B. Jenkins		FEDERAL DEPARTMENT OF HEALTH SIGNATURE Illinois Ave. St. Joseph, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

B. J. Chaney

Student Embalmer No. **294**

working under my personal supervision.

Signed *B. J. Chaney*
Student Embalmer

Signed *Earl A. Clark*

Licensed Embalmer No. **4238**

P. O. Address St. Joseph, 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 this body is not embalmed, fact should be so stated above.