

FILED OCT 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 30711

BIRTH NO. _____		REG. DIST. NO. 150		PRIMARY REG. DIST. NO. 5572		Registrar's No. 159	
1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JACKSON			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL PRAIRIE TWP		c. LENGTH OF STAY (in this place) 2-6-7		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY MO		48	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION JACKSON HOME INDEP. MO RR #4				d. STREET ADDRESS (If rural, give location) 1506 CENTRAL			
3. NAME OF DECEASED (Type or Print) a. (First) LONNIE			b. (Middle) DUNCAN		c. (Last) DUNCAN		
4. DATE OF DEATH (Month) (Day) (Year) 9 18 1949		5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	
8. DATE OF BIRTH 1-17-1887		9. AGE (In years last birthday) 62		10. MONTHS 8		11. DAYS 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) BELTON MO		12. CITIZEN OF WHAT COUNTRY? MO	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE W-			
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. No		17. INFORMANT'S SIGNATURE OR NAME OR #4 ADDRESS JACKSON Co HOME RECORDS INDEP-MO			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mitral regurgitation					
		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.				4/10X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/11, 1947 to 9/18, 1949, that I last saw the deceased alive on 9/17, 1949, and that death occurred at 10:30 A.M., from the causes and on the date stated above.							
23a. SIGNATURE J. H. Greene M.D. (Degree or title)				23b. ADDRESS Independence Mo		23c. DATE SIGNED 9/19/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/20/49		24c. NAME OF CEMETERY OR CREMATORY Leis Summit		24d. LOCATION (City, town, or county) (State) Leis Summit Mo	
DATE REC'D BY LOCAL REG. SEPT. 20, 1949		REGISTRAR'S SIGNATURE Donald C. Emswiler 378		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS N. B. Langford Leis Summit Mo			

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

SEP 30 RECD

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**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.

Signed

*W. B. Langford*

Signed.....

Student Embalmer

Licensed Embalmer No.

*3833*

P. O. Address

*Leis, Quinman*

**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.