

FILED DEC 31 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHSTATE FILE NUMBER  
44595

Registration District No. 373 Primary Registration District No. 4545 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY <b>WEBSTER</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>								
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MARSHFIELD MO</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>MARSHFIELD MO</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in 1b <b>7 MO</b>		d. STREET (If outside, give location) ADDRESS <b>526 S MARSHALL</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year		
<b>MARY</b>			<b>MANUWA</b>	<b>DUCHE</b>	<b>DEC 16 1956</b>							
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.		
<b>FEMALE</b>	<b>WHITE</b>	<b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>NOV 3 1864</b>	<b>92</b>								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY?					
<b>HOUSEWIFE</b>					<b>MISSOURI</b>		<b>USA</b>					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME						
<b>ABRAHAM HARGUS</b>						<b>LOUISA MITCHELL</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT					Address		
<b>NO</b>					<b>ORA MCCAW ONTARIO CABIE</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MEDULLARY FAILURE</b>												
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												
DUE TO (b) <b>THROMBOTIC ENCEPHALOMALACIA</b>												
DUE TO (c) <b>ARTERIOSCLEROSIS</b>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
										<b>332X</b>		
20a. ACCIDENT	SUICIDE	HOMICIDE	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
20c. TIME OF INJURY	Hour	Month, Day, Year										
	a. m.	p. m.										
20d. INJURY OCCURRED	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION									COUNTY	STATE
WHILE AT WORK <input type="checkbox"/>	NOT WHILE AT WORK <input type="checkbox"/>											
21. I attended the deceased from <b>6/1/56</b> to <b>12/16/56</b> and last saw her <sup>him</sup> alive on <b>12/15/56</b> Death occurred at <b>900 A. M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE (Degree or title)				22b. ADDRESS		22c. DATE SIGNED						
<b>[Signature]</b>				<b>MO. 2</b>		<b>Marshfield, Mo. 12/21/56</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)			23e. (State)			
<b>BURIAL</b>		<b>12-18-1956</b>	<b>BLACK OAK</b>			<b>WEBSTER CO MO</b>						
24. FUNERAL DIRECTOR				ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE				
<b>BARBER-EDWARDS</b>				<b>MARSHFIELD MO</b>		<b>12-16-56</b>		<b>[Signature]</b>				

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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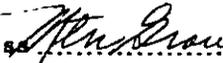
STATEMENT BY LICENSED EMBALMER

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..

Student.....  
Signature of Student Embalmer

Signed.....  


Licensed Embalmer No. 35

P. O. Address 

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.