

Health,  
& Welfare  
Public  
Service

FILED OCT 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35106  
STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. 4099 Registrar's No. 155

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Cast. Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Pleasant Hill</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. FULL NAME OF (If NOT in hospital, give location) <u>109 N. Anthony</u>		d. STREET ADDRESS <u>4216 E. 69th St.</u>	
Length of stay in 1b <u>7 1/2 mo</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>THELMA LEE DUNCAN</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>1957</u>		
---	--	--	---	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 28 1898</u>	9. AGE (In years last birthday) <u>59</u>	10. FUNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
----------------------	-------------------------------	---	-------------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>San Marcus Texas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	---	---	---

13. FATHER'S NAME <u>J. L. Schofield</u>	14. MOTHER'S MAIDEN NAME <u>Ida Lovelace</u>	15. NAME OF HUSBAND OR WIFE <u>Ralph B. Duncan</u>
--	--	--

16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>Ralph B. Duncan 4216 E 69th St KC Mo.</u>
---	-------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension, essential severe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>444X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART-II of item 18.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____
---	---	--	---

21. I attended the deceased from <u>13 May '57</u> to <u>23 Oct '57</u> and last saw her/him alive on <u>17 Sept 57</u> Death occurred at <u>8:45</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>W. G. [Signature] M.D.</u>	22b. ADDRESS <u>Pleasant Hill, Mo.</u>	22c. DATE SIGNED <u>10-25-57</u>
---	---	-------------------------------------

23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 25 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orient Cemetery</u>	23d. LOCATION (City, town, or county) <u>Harrisonville Mo</u>
---	---------------------------------	--	--

24. FUNERAL DIRECTOR <u>Dunnenburger Harrisonville Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 25 1957</u>	26. REGISTRAR'S SIGNATURE <u>Dora Barward</u>
---	--	--

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

57  
0

NOV 8 1957

RECEIVED  
OCT 28 1957  
CAS. ...  
HEALTH DEPARTMENT

NOV 12 1957

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 Ernest M. Gammberger

Licensed Embalmer No. 3368  
P. O. Address Harrisonville

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.