

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-049184

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 244

FILED DEC 18 1962

VS 300
Rev. 4/59

10975
3970

3

4 0

5 1

6

7 0

8 0

9602X

10

11

12 1-0

13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ,

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Saline</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		c. CITY OR TOWN <u>Gilliam</u>	
Length of stay in 1b <u>4 days</u>		Inside Limits (if outside, give location) d. STREET ADDRESS <u>R. R. #1</u>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbon Hospital</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Asa</u> Middle <u>Everett</u> Last <u>Duncan</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>8</u> Year <u>1962</u>
5. SEX <u>Male</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>12-20-1891</u>
9. AGE (last birthday) <u>70</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	11. BIRTHPLACE (City and state or country) <u>Saline City, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>James Monroe Duncan</u>	
13b. MOTHER'S MAIDEN NAME <u>Hannah Jane Johnson</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Jane Bernett</u>	
15. 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. _____	
17. INFORMANT <u>Mrs. Asa Duncan</u>		Address <u>Gilliam, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line if PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. nephritis & uremia</u> DUE TO (b) <u>Renal calculi - Bilateral</u> DUE TO (c) <u>Draining st. renal abscess</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>? - 2 wks.</u> <u>14 years</u> <u>2 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <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>Jan. 1941</u> to <u>Dec. 8, 1962</u> and last saw ^{him} alive on <u>Dec. 8, 1962</u> Death occurred at <u>9:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>C. A. McBurney M.D.</u> (Degree or title)		22b. ADDRESS <u>Slater, Mo.</u>	
22c. DATE SIGNED <u>12-8-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Dec. 10, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Slater City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Slater, Missouri</u>	
24. FUNERAL DIRECTOR <u>Braun Funeral Home</u> ADDRESS <u>Slater, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec. 10-'62</u>	
		26. REGISTRAR'S SIGNATURE <u>Cecil D. Reed</u>	

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 Robert J. Braun

Licensed Embalmer No. 5183

P. O. Address Slater, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.