

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-017599

STATE FILE NUMBER

FILED JUN 2 1958 Registration District No. 41 Primary Registration District No. 3012 Registrar's No. 46

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Clay</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Excelsior Springs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Excelsior Springs</b> 60020		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>100 E. Excelsior</b>		Length of stay in 1b <b>Lifetime</b>	d. STREET ADDRESS (If outside, give location) <b>100 E. Excelsior</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLEY ALLEN DUNCAN</b>			4. DATE OF DEATH Month Day Year <b>May 12, 1958</b>		
5. SEX <b>Male</b> 0	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 30, 1896</b>		9. AGE (In years last birthday) <b>61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Produce</b>	11. BIRTHPLACE (City and state or country) <b>Ray County, Mo.</b> 0		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Willard Duncan</b>		13b. MOTHER'S MAIDEN NAME <b>Josephine O'Dell</b>		14. NAME OF HUSBAND OR WIFE <b>Helen M. Duncan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>491-01-9104</b>		17. INFORMANT <b>Helen Duncan, 100 E. Excelsior, Excelsior Springs, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General debility, starvation</b>				INTERVAL BETWEEN ONSET AND DEATH <b>9 mo.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma Mediastinal shift</b>				<b>6 mo.</b>	
DUE TO (c) <b>Carcinoma Bronchus</b>				<b>9 mo.</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>1621</b>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.					
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 <b>May 5</b> to <b>1957</b> and last saw her alive on <b>5-11-58</b> Death occurred at <b>about 9:00 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>David Musgrave M.D. 0</b>			22b. ADDRESS <b>Excelsior Springs Mo</b>		22c. DATE SIGNED <b>5-16-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-14-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Masonic Cemetery</b>		23d. LOCATION (City, town, or County) (State) <b>Excelsior Springs, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Prichard Funeral Home, Inc.</b>			25. DATE RECD. BY LOCAL REG. <b>5-26-58</b>		26. REGISTRAR'S SIGNATURE <b>Caroline Hutchings</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

JAN 9 1959

JUN 16 1958



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 *Lindell Jarman*

Licensed Embalmer No. *4589*

P. O. Address *Excelsior Springs, 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.