

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

11669

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

503

City.....

No. 3925 Castleman ave

File No.....

Registered No. 3516

St. Ward)

2. FULL NAME

Leslie Duncan

(a) Residence No..... St. 17 Ward.....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Sadie Duncan

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Aug 27 - 1904

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>23</i>	<i>7</i>	<i>1</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

Machinist

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

10. NAME OF FATHER

John M. Duncan

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

12. MAIDEN NAME OF MOTHER

Bell Fair

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Kentucky

14.

INFORMANT *Roy Duncan*

(Address) *3925 Castleman ave*

15.

FILED *29* 19*28* *May C. Starkey*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-28 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Mar 18th* to *Mar 27th*, 19*28* (that I last saw him alive on *March 27*, 19*28*), and that death occurred, on the date stated above, at *3* *4* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

121A
129
Bacterial Appendicitis
(duration)..... yrs. mos. *12* da.

CONTRIBUTORY (SECONDARY) *Local peritonitis*
(duration)..... yrs. mos. *8* da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *March 18/28*

20. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *John D. Stewart* M.D.
(Address) *Metropolitan Bldg*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Park Hill *March 30 1928*

20. UNDERTAKER ADDRESS

Edm. P. Howard & Son *4212 St Louis ave*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

