

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

Do not use this space.

31710
291

1. PLACE OF DEATH

County Laurens Registration District No. 467
Township Aurora Primary Registration District No. 4280
City Aurora (No. 1291 1111 South St.)

File No.
Registered No.
St. Ward)

2. FULL NAME

(a) Residence, No. 29 South St. St. Ward.

(If nonresident, give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Josephine Duckworth</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb 16 - 1836</u>		
7. AGE	YEARS	MONTHS
	<u>75</u>	<u>6</u>
		DAYS
		<u>24</u>
		If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Real Estate Dealer</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Franklin Co Mo</u>		
FATHER	13. NAME <u>Josiah Duckworth</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>N. E</u>	
MOTHER	15. MAIDEN NAME <u>Elizabeth Stovall</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Impover</u>	
17. INFORMANT <u>William Duckworth</u> (ADDRESS) <u>1111 South St.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. Charles Mo</u> DATE <u>9/11</u> (31)		
19. UNDERTAKER <u>King Funeral Home</u> (ADDRESS) <u>Aurora Mo</u>		
20. FILED		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 9 1931

22. I HEREBY CERTIFY, That I attended deceased from May 9 1929 to Sept 9 1931
I last saw him alive on Sept 9 1931 Death is said to have occurred on the date stated above, at 6:15 p.m.
The principal cause of death and related causes of importance were as follows:
acute nephritis

Date of onset with

Other contributory causes of importance:

Name of operation Prostatectomy Date of 5-9-29
What test confirmed diagnosis? Chemical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed), M. D.
(Address)

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.

OCT 24 1931

Registrar.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Lawrence Registration District No. 467 File No. _____
 Township _____ Primary Registration District No. 7280 Registered No. 291
 City Amoria (No. _____) St. _____ Ward _____

2. FULL NAME

Josiah Clark Duckworth

(a) Residence No. _____ St. _____ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
- (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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED

19.

Bill Smart
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/9 19 31

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, (that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above) _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Nephritis
superficially acute
interstitial. Abstinence many weeks
(duration) _____ yrs. _____ mos. _____ da.

CONTERBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Bill Smart M.D.
, 19 (Address) Amoria

*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

19

20. UNDERTAKER

ADDRESS

WHITE PLAINLY, WITH UNFADING INK

Every item of information should be carefully supplied. It should be stated EXACTLY. PHYSICIANS should state exact statement of OCCUPATION in very plain terms, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED IN THE REGULATIONS.

SUPPLEMENTARY

S-31710