

JAN 17 1940

Registration District No. 496

Primary Registration District No. 3025

Registrar's No. 111

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town Brookfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: McDermey Hospital 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 30 days  
(Specify whether  
In this community. 40 years  
years, months or days)

3. (a) PRINT FULL NAME Elizabeth Duckett  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife William Duckett 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased. April 29 - 1853  
(Month) (Day) (Year)

8. AGE: Years 86 Months 7 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace. Woodlawn Wis.  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business 5

12. Name Cooney

13. Birthplace Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name Do not know  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Grace Barber  
(b) Address Brookfield

17. (a) Removal (b) Date thereof Dec 7 39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St Olivet Bern Chicago Hill Funeral Chapel

18. (a) Signature of funeral director St Olivet Bern Chicago Hill Funeral Chapel  
(b) Address Brookfield - Mo. 41114

19. (a) Dec 6-39 (b) Grace Barber  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn  
(c) City or town Brookfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 223 E. Clark  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 4<sup>th</sup>  
year 1939 hour 10 minute 15 P.M.

21. I hereby certify that I attended the deceased from June 1937 to 12-9 1939;  
that I last saw her alive on 12-9 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Liver Duration 2 yrs

Due to \_\_\_\_\_  
Due to Hb

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy None

PHYSICIAN  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. E. Smith (M. D. or other) MD  
Address Brookfield Mo Date signed 11/6/39

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.

MOTHER FATHER

RECEIVED

District Health Officer No. 111

FILE NO. 140-1946

Date Filed JUN 18 1946

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.....

*J. M. Blacklock*  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *J. M. Blacklock*  
.....

Licensed Embalmer No. *2246*  
.....

P. O. Address *Brookfield, Ill.*  
.....

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 this body is not embalmed, above space should be left blank.