S. No. 2
M—2-43
. 5-17-39
-1 X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 11 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17970

Registration District No. 316 — Primary Registration District No. 6075 — Registrar's No. 41

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 yrs. 1 mo. 24 dns. (Specify whether
In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")

(d) Street No. 8705 Eulalie
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME JAMES EDWIN DUCKWORTH

3. (b) If veteran, name war Unknown

3. (c) Social Security No. None

4. Sex Male

5. Color or race W.

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ____

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased April (Month) 14 (Day) 1908 (Year)

8. AGE: Years 37 | Months 1 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation None

11. Industry or business ____

FATHER
12. Name John Arthur Percy Duckworth
13. Birthplace Clarksville (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Katherine C. Sandboth
15. Birthplace St. Louis, (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Records State Hospital No. 4
(b) Address Farmington, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Lebanon Cem., St. Louis, Mo.

18. (a) Signature of funeral director Geo. L. Pleitsch
(b) Address 5966 Easton Ave., St. Louis, Mo.

19. (a) 5/29/45 (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23 year 1945 hour 4 minute 00 P. M.

21. I hereby certify that I attended the deceased from April 1, 1943, 19__, to May 23, 1945, 19__; that I last saw him alive on May 23, 1945, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Pulmonary Tuberculosis.

Due to ____

Due to ____

Other conditions ____
(Include pregnancy within 3 months of death)

Major findings:
Of operations ____
Of autopsy No autopsy.

Duration

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

23. Signature [signature] (M. D. or other) [signature]
Address [illegible] Date signed 5-29-45

1399 (Licensed Embalmer's Statement on Reverse Side) Farmington, Mo.

RECEIVED

District Health Officer No. 4

District File Number 645-731

Date Filed 6-7-45

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 ....., Registered Apprentice No. ....., working under my personal supervision.

Signed Leonard W. Kraeger

Licensed Embalmer No. 2678

P. O. Address St. Louis 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 this body is not embalmed, fact should be so stated above.