No. 2
1-4-41
17-39
X28390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 15 1948

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 43924

Registration District No. 223 | Primary Registration District No. 3074 | Registrar's No. 13

1. PLACE OF DEATH:

(a) County: Scott

(b) City or town: Sikeston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 305 Lescher Drive
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... In this community: 25 yr
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Scott 100

(c) City or town: Sikeston 5
(If outside city or town limits, write "RURAL")

(d) Street No.: 305 Lescher Drive 5
(If rural, give location)

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

If yes, name country: —

3. (a) PRINT FULL NAME: CHARLES WICKLIFFE DUNCAN

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Orilla

6. (c) Age of husband or wife if alive: 80 years

7. Birth date of deceased: March 13 1865 (Month) (Day) (Year)

8. AGE: Years: 82 | Months: 8 | Days: 19 | If less than one day: ..... hr. ..... min.

9. Birthplace: Vallonia (City, town, or county) Ind (State or foreign country)

10. Usual occupation: Ret Carpenter

11. Industry or business:

FATHER
12. Name: James W Duncan
13. Birthplace: Ind (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant: Ray Duncan
(b) Address: Sikeston Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-5-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Sikeston Mo

18. (a) Signature of funeral director: Welch Funeral Home
(b) Address: Sikeston Mo

19. (a) 12-31-47 (Date received local registrar) (b) Mrs T. F. Henry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec day: 2 year: 1947 hour: 11 minute: 30 P.M.

21. I hereby certify that I attended the deceased from Nov 14, 1947 to Dec 2, 1947 that I last saw him alive on Dec 2, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to: Pneumonia	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Senility	

Major findings:
Of operations:
Of autopsy:

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: 0

23. Signature: E. J. Niemstedt (M. D. or other)
Address: Sikeston Mo Date signed: Dec 4 47

(Licensed Embalmer's Statement on Reverse Side)

DEC 17 1948

RECEIVED
District Health Office No. 2,
District File Number 48-53
Date Filed 1-9-48

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 13

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Charles W. Duncan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 13 (Day) 1866 (Year)

8. AGE: Years 82 Months 8 Days 19 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 2
year 1947 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw him alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 108

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 [illegible] (M. D. or other)

Address Sikeston Mo Date signed 1-19-48

SUPPLEMENTARY

43924