

S. No. 300
M-10-47
v. 5-17-39
I 3906

FILED MAR 10 1948
Registration District No. **3481**

Primary Registration District No. **6178**

Registrar's No. _____

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

1. PLACE OF DEATH: **Sullivan**

(a) County **Sullivan**

(b) City or town **Rural Browning Duncan**
(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 **life** (Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Sullivan 105**

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

(d) Street No. **Duncan Prop.**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME **Willis E. Duckworth**

3. (b) If veteran, name war: **---**

3. (c) Social Security No. **---**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2** day **23**
year **1948** hour **8** minute **20** P. M.

4. Sex **M** 5. Color or race **W**

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

6. (b) Name of husband or wife **Alice Duckworth**

6. (c) Age of husband or wife if alive **73** years

7. Birth date of deceased: **Nov 23 1868**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Feb 1 1948** to **Feb 23 1948**
and that death occurred on the date and hour stated above.

8. AGE: **79** yrs **3** Months **0** Days
If less than one day hr. min.

Immediate cause of death **Cerebral hemorrhage** Duration **45 hrs**

Due to _____

Due to _____

9. Birthplace **Sullivan Co. Missouri**
(City, town, or county) (State or foreign country)

Other conditions **Arteriosclerosis**
(Include pregnancy within 3 months of death)

Major findings: **Cerebral hemorrhage 1946**

10. Usual occupation **Farmer**

11. Industry or business **William S. Duckworth**

MOTHER FATHER { 12. Name **Virginia**

13. Birthplace **North Hove Tenn.**
(City, town, or county) (State or foreign country)

14. Maiden name **Alice Duckworth**

15. Birthplace **Sullivan Co. Missouri**
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant **Browning**

(b) Address **Burial 2-26-48**

17. (a) **Burial** (b) Date thereof **Hover**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wade Funeral Home**

18. (a) Signature of funeral director **Browning, Mo.**

(b) Address _____

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? _____

19. (a) **March 2-1948** **Mrs. H. B. Harris**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury **0**

23. Signature **J. R. M. Arls** (M. D. or other)
Address **Browning Mo** Date signed _____

VS
MAY 6
1959

RECEIVED
District Health Officer No. 10
District File Number 3-48-458
Date MAR 8 1948

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 Gerald I. Wade

Licensed Embalmer No. 4172

P. O. Address Browning

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.