S. No. 2
M—1/47
v. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14967

FILED MAY 15 1948

Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 1069

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 858 days (Specify whether
In this community 28 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4311a Cook Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME DUNCAN, DOKIE MOSES
3. (b) If veteran, name war World War I
3. (c) Social Security No. 492-09-9876
4. Sex Male 9
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Prudence Fletcher Duncan
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 10 (Day) 1896 (Year)

8. AGE: Years 51 | Months 11 | Days 14 | If less than one day br. min.

9. Birthplace Plummersville (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation Factory
11. Industry or business
FATHER
12. Name Joseph Duncan
13. Birthplace (City, town, or county) Mississippi (State or foreign country)
MOTHER
14. Maiden name Lillian McKindra
15. Birthplace (City, town, or county) Tennessee (State or foreign country)
16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-30-48 (Month) (Day) (Year)
(c) Place: burial or cremation Morrillton, Ark.
18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Ave.
19. (a) 4-27-48 (Date received local registrar) (b) Leal J. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24 year 1948 hour 11 minute 42 A. M.

21. I hereby certify that I attended the deceased from 12-18-45, 19..., to 4-24-48, 19...; that I last saw him alive on 4-24-48, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	3 yrs. (???)
Due to	
Due to 13 b	
Other conditions (Include pregnancy within 3 months of death): Possible Pneumoconiosis	???

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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 William C. Banton II (M. D. ~~or other~~)
Address Robert Koch Hospital Date signed 4-26-48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

JUN 7 1946

JUN 1 6 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 Thomas J. Gates, Registered Apprentice No. _____, working under my personal supervision.

Signed Thomas J. Gates

Licensed Embalmer No. 4259

P. O. Address 4107 7

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.