

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31432

State File No.

FILED OCT 10 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8272**

1. PLACE OF DEATH a. COUNTY St. Louis, Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 20 2601 Elliot	

3. NAME OF DECEASED (Type or Print) a. (First) Amos	b. (Middle) Duncan	c. (Last) Duncan	4. DATE OF DEATH (Month) (Day) (Year) Sept. 16 1951
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 30, 1884	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 2 Days 16	IF UNDER 24 HRS. Hours 1 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Lawrence, Kansas	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Amos Duncan, Sr.	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Elsie Duncan
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 488-01-8600	17. INFORMANT'S SIGNATURE OR NAME Mrs. Frances Woods	ADDRESS 3128 School
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 4 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease		Undet.
	DUE TO (c) Undetermined		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200
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22. I hereby certify that I attended the deceased from **9-14**, 19 **51**, to **9-16**, 19 **51**, that I last saw the deceased alive on **9-16**, 19 **51**, and that death occurred at **10 p** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. Harris M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 9-17-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) 11	24b. DATE 9/27/51	24c. NAME OF CEMETERY OR CREMATORY St. Peters	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. SEP 18 1951	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE E. B. Boone	ADDRESS 1221 N. Grand
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....

X

..... Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed

Clarence Croome

Licensed Embalmer No. *4755*

P. O. Address *1221 N. York*

↓ 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.