

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 2 - 1953

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 981

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>	c. LENGTH OF STAY (In this place) <u>4 1/2 yrs.</u>	c. CITY (If outside of Springfield, give county and township) <u>Rural R. - 9 0390</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Johns Hosp'tl.</u>		d. STREET ADDRESS (If rural, give location) <u>Route #9</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u> b. (Middle) <u>ROBERT</u> c. (Last) <u>DUKE</u>	4. DATE OF DEATH (Month) <u>10</u> (Day) <u>27</u> (Year) <u>53</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-6-89</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farms</u>	11. BIRTHPLACE (State or foreign country) <u>Greene Co' Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13a. FATHER'S NAME <u>Robert Duke</u>	13b. MOTHER'S MAIDEN NAME <u>Lucy (?)</u>	14. NAME OF HUSBAND OR WIFE <u>Ruby Duke</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes World W. I</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ruby Duke</u>
		ADDRESS <u>R.F.D. 9 Springfield Mo</u>

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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 mos</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <u>Malignant hypertension</u>		
	DUE TO (c) _____		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>445X</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-19, 1953, to 10-27, 1953, that I last saw the deceased alive on 10-26, 1953, and that death occurred at 4:14 A. m., from the causes and on the date stated above.

23a. SIGNATURE <u>S. Lemmon</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Springfield, Mo.</u>	23c. DATE SIGNED <u>10-29-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>Nov-1-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem'</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield Mo</u>
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DATE REC'D BY LOCAL REG. <u>10-29-53</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H.V. Smith</u>	ADDRESS <u>602 N Jefferson Springfield Mo</u>
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Herbert V. Smith

Licensed Embalmer No. _____

4286

P. O. Address _____

Springfield

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.