FILED APR 6 - 1956

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 10641

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3236

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St.Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St.Luke's Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Franklin
c. CITY OR TOWN: St.Clair
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): 110 Springfield Ave. 0360 1

**3. NAME OF DECEASED** (Type or Print)
a. (First): WILBUR
b. (Middle): J.
c. (Last): DUCKWORTH

**4. DATE OF DEATH** (Month) (Day) (Year): March 29,1956

**5. SEX**: Male
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Divorced
**8. DATE OF BIRTH**: Feb.8,1906
**9. AGE** (In years last birthday): 50 — 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): Collector
**10b. KIND OF BUSINESS OR INDUSTRY**: Collection Agency
**11. BIRTHPLACE** (City and State or Foreign Country): St.Clair,Mo.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13a. FATHER'S NAME**: William Duckworth
**13b. MOTHER'S MAIDEN NAME**: Lena Jennings
**14. NAME OF HUSBAND OR WIFE**: Unavailable

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes, give war or dates of service): None
**16. SOCIAL SECURITY NO.**: None
**17. INFORMANT'S SIGNATURE OR NAME** / ADDRESS: Donald Duckworth, St.Clair,Mo.

**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.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma metastatic to liver lung, left thoracic wall, & skull
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Primary not determined
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Paraplegia, sec to hematoma of cord - old. Chronic alcoholism

INTERVAL BETWEEN ONSET AND DEATH: unknown

**19a. DATE OF OPERATION**: Jan 16, 1956
**19b. MAJOR FINDINGS OF OPERATION**: Subdural hematoma of spinal cord 1998
**20. AUTOPSY?** YES ☒ NO ☐

**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) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* Jan 23, 1956, *to* Mar 29, 1956, *that I last saw the deceased alive on* Mar 28, 1956, *and that death occurred at* 11:20 A.m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): George E. Rouhac MD
**23b. ADDRESS**: 3720 Washington Ave
**23c. DATE SIGNED**: Mar 29, 1956

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Removal
**24b. DATE**: 3-30-56
**24c. NAME OF CEMETERY OR CREMATORY**: IOOF Cemetery
**24d. LOCATION** (City, town, or county) (State): St.Clair,Mo.

**DATE REC'D BY LOCAL REG.**: MAR 30 1956
**REGISTRAR'S SIGNATURE**: J. Carl Smith MD MDB
**25. FUNERAL DIRECTOR'S SIGNATURE** / ADDRESS: Albert H.Hoppe,4700 Washington Blvd.

(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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Stanley H. Dixon

Licensed Embalmer No. 4.

P. O. Address St. L.

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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