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 Doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms with no signs. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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

FILED FEB 25 1957

318

1003

STATE FILE NUMBER 1283

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

|   |                                  |   |   |  |  |
|---|----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN<br><b>St. Louis</b>   |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY<br>OR<br>TOWN<br><b>St. Louis</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION<br><b>St. Louis<br/>City Hospital #1</b>  |                                  | Length of stay in 1b<br><b>4 weeks 2 1/2</b>  | d. STREET ADDRESS<br><b>3850a Labadie Avenue</b>  |  | (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Clintie First Middle R Last Duncan<br/>Clint R Duncan</b>  |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>2 6 57</b>   |  |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 31 1895</b>  |  | 9. AGE (In years last birthday)<br><b>61</b><br>IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Freight Checker (Retired)</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Rock Island RR</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>Mansfield, Arkansas</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                  |   | 13. FATHER'S NAME<br><b>James Duncan</b>  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Susie Cherry</b>   |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  |  |
| 16. SOCIAL SECURITY NO.<br><b>488-03-8445</b>   |                                  |   | 17. INFORMANT Address<br><b>Mrs. Edna Duncan, 3850a Labadie Ave</b>   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) <b>Chronic Obstructive Emphysema</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>527.1.</b> |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a. m. p. m.   |                                  |   |   |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |   | 20f. CITY, TOWN, OR LOCATION COUNTY STATE                                |  |
| 21. I attended the deceased from <b>1 - 10 - 57</b> to <b>2 - 6 - 57</b> and last saw her/him alive on <b>2 - 6 - 57</b><br>Death occurred at <b>11:30 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.  |                                  |   |   |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>Wesley C. Carr M.D.</b>  |                                  |   | 22b. ADDRESS<br><b>1515 Lafayette</b>   |  | 22c. DATE SIGNED<br><b>2-7-57</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |                                  | 23b. DATE<br><b>Feb 11 1957</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Hill Gardens Cemetery</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Missouri</b>                         |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Math Hermann &amp; Son, Inc., 2161 E. Fair Av</b>  |                                  |   | 25. DATE RECD. BY LOCAL REG.<br><b>FEB 8 '57</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>Carl Smith MD</b>  |

(Licensed Embolmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

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

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Allen W. Napp*

Licensed Embalmer No. 31

P. O. Address *St. Louis*

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.