

Health,  
Welfare  
Public  
Service

FILED OCT 9 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31819  
STATE FILE NUMBER  
4389  
Registrar's No.

Registration District No. 149 Primary Registration District No. 1002

300  
-57

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4206 SPRUCE</u>			Length of stay in 1b <u>2 1/2 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>4206 SPRUCE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>CHESTER</u> Middle <u>HUGH</u> Last <u>DUCKWORTH</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>19</u> Year <u>1957</u>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 6, 1903</u>		9. AGE (In years last birthday) <u>54</u>		10. FUNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERVISOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Steele Tank &amp; BUTLER MFG. CO.</u>		11. BIRTHPLACE (City and state or country) <u>ALBANY, MISSOURI</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13a. FATHER'S NAME <u>JOHN DUCKWORTH</u>				13b. MOTHER'S MAIDEN NAME <u>LAURA MARSH</u>				14. NAME OF HUSBAND OR WIFE <u>ANNA DUCKWORTH</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>487-05-7538</u>		17. INFORMANT <u>M.</u> Address <u>4206 SPRUCE K. C., MO.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Multiple previous myocardial infarcts</u>										5 years.			
DUE TO (c)										4201			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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 Hour a.m. p.m. Month, Day, Year													
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 <u>Jan 21, 1952</u> to <u>Sept 19, 1957</u> and last saw him alive on <u>Sept 5, 1957</u> Death occurred at <u>6:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Martin P. Hunter M. D.</u>						22b. ADDRESS <u>1408 Waldheim Bldg.</u>				22c. DATE SIGNED <u>9/20/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-21-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>				23d. LOCATION (City, town, or County) (State) <u>K. C., Mo.</u>					
24. FUNERAL DIRECTOR <u>D. W. NEWCOMER'S SONS</u>				ADDRESS <u>1331 BROWN CROSS K. C., MO.</u>		25. DATE RECD. BY LOCAL REG. <u>9-21-57</u>		26. REGISTRAR'S SIGNATURE <u>Drewa Marshall</u>					

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Martin P. Hunter



**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 .....  
Signature of Student Embalmer

Signed *Raymond M. Hardy* .....

Licensed Embalmer No. *4913* .....  
P. O. Address *Indep. Mo.* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.