

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 23 1960

=60-020862

STATE FILE NUMBER

2 4372

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>ST. LOUIS</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>23 days</b>	c. CITY OR TOWN <b>Pine Lawn</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis - Little Rock Hospitals, Inc.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3913 Jennings Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Floyd</b> Middle <b>James</b> Last <b>Duncan</b>			4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-8-1912</b>	9. AGE (last birthday) <b>48</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Switchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and state or country) <b>ROLLA-MO</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
13a. FATHER'S NAME <b>NOAH DUNCAN</b>		13b. MOTHER'S MAIDEN NAME <b>MARGARETTE CARTER</b>		14. NAME OF HUSBAND OR WIFE <b>ola DUNCAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>497-01-5882</b>		17. INFORMANT Address <b>Ma Ala Duncan, GENUINES RD 3913</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>CEREBRAL EMBOLUS</b>					<b>30 MIN.</b>
DUE TO (b) <b>RELEASE <sup>from</sup> THROMBUS LEFT AURICLE</b>					<b>INDETER.</b>
DUE TO (c) <b>MITRAL STENOSIS - RHEUMATIC</b>					<b>INDETER. LONG STAMP.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ISCHEMIA OF RT. LEG DUE TO EMBOLUS -</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>March 30, 1960</b> to <b>April 21, 1960</b> and last saw <del>her</del> him alive on <b>April 21, 1960</b> Death occurred at <b>7:50 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Devon H. Coffman M.D.</b>			22b. ADDRESS <b>3720 WASHINGTON TOOD</b>		22c. DATE SIGNED <b>22 APRIL 60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL APRIL 23-1960</b>		23b. DATE <b>APRIL 23-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CITY CEMETERY</b>	
23d. LOCATION (City, town, or county) (State) <b>SUMMERSVILLE - MO</b>		24. FUNERAL DIRECTOR ADDRESS <b>L. B. Tanner, 6107 Natural Bridge</b>		25. DATE RECD. BY LOCAL REG. <b>APR 23 1960</b>	
26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

m j e.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Elmer R Caldwell

Licensed Embalmer No. 4077

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.