

9-20-60  
 Deltha Ducey  
 DOCUMENT  
 Deltha Ducey  
 MEDICAL CERTIFICATION  
 Deltha Ducey  
 BY AFFIDAVIT OF Informant

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Pike</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>Pittsfield</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes, Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Donald D. C. Ducey</b>				4. DATE OF DEATH Month Day Year <b>Aug 13 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>8-6-1920</b>		9. AGE (last birthday) <b>40</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Pittsfield, Ill</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Arthur Ducey</b>			13b. MOTHER'S MAIDEN NAME <b>Sarah McCaughey</b>			14. NAME OF HUSBAND OR WIFE <del>Deltha</del> <b>Deltha Ducey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes W.W. 2 Navy</b>			16. SOCIAL SECURITY NO. <b>349-01-8718</b>		17. INFORMANT Address <b>George McGann Pittsfield, Ill</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage, intracerebellar etiol.</b> DUE TO (b) <b>undet. - Hemorrhage, suspected. emboli, pulmonary, multiple</b> DUE TO (c) <b>228x</b> CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>2 days.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hemorrhage left temporal lobe Brain nec. to hemorrhage</b> <b>10 Nov. 1960</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N. <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>8-9-60</b> to <b>8-13-60</b> and last saw her/him alive on <b>8-13-60</b> Death occurred at <b>5:35 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22. SIGNATURE (Degree or title) <b>George E. Rosehart M.D.</b>				22b. ADDRESS <b>3720 Washington Ave</b>				22c. DATE SIGNED <b>8-15-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-16-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		23d. LOCATION (City, town, or county) <b>Pike County, Ill</b>		(State)		
24. FUNERAL DIRECTOR ADDRESS <b>Albert R. Hoppe 4700 Washington</b>				25. DATE RECD. BY LOCAL REG. <b>AUG 15 1960</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>			

**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

*J W M Dumbley*

Licensed Embalmer No. \_\_\_\_\_

*365*

P. O. Address \_\_\_\_\_

*St Louis 8*

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