

1000  
 1939  
 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

State File No. 44665

ST. LOUIS 8 1939  
 Registration District No. 764

Primary Registration District No. 111

Registrar's No. 2227

1. PLACE OF DEATH:  
 (a) County St. Louis County  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Mary's Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Dent  
 (c) City or town Salem  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Keith Duckworth  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Dec day 16  
 year 1939 hour 5 minute A M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Child  
 6. (b) Name of husband or wife Child 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased June 10 1931  
 (Month) (Day) (Year)

Immediate cause of death:  
Traumatism of the throat, due to running a stick thru his mouth and causing a punctured wound injuring the left external carotid artery. 12/7/39  
 Duration \_\_\_\_\_  
 Other conditions: (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 8 Months 6 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace Salem Missouri  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Child

Major findings: Of operations 185  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

11. Industry or business \_\_\_\_\_  
 MOTHER FATHER {  
 12. Name Cutch Duckworth  
 13. Birthplace Salem Missouri  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Mildred Williams  
 15. Birthplace Texas Co. Missouri  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Cutch Duckworth  
 (b) Address Salem, Mo.  
 17. (a) Removal (b) Date thereof 12/18/39  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Salem, Mo.  
 18. (a) Signature of funeral director Albert H. Hoppe Inc.  
 (b) Address 4700 Washington Blvd.  
 19. (a) DEC 18 1939 (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) accident  
 (b) Date of occurrence Dec 7, 1939  
 (c) Where did injury occur? Salem, Mo.  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home  
 While at work? no (Specify type of place) (a) Means of injury Fall with stick  
 28. Signature J. O. Conull (M. D. or other) \_\_\_\_\_  
 Address Coyoner of St. Louis County Date signed 12/16

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**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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

*Robert W. Kappeler*

Licensed Embalmer No. 1861

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**