S. No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 9 1949

Registration District No. 9

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5306

Primary Registration District No. 1002

Registrar's No. 756

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community 23 years

2. USUAL RESIDENCE OF DEACESED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 1222 ½ Campbell
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Susan Catherine Duckworth
3. (b) If veteran, name war: no
3. (c) Social Security No.: none
4. Sex: Fe 1
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: Robert Duckworth
6. (c) Age of husband or wife if alive: Deceased years
7. Birth date of deceased: Dec. (Month) 25th. (Day) 1883 (Year)

8. AGE: Years	Months	Days	If less than one day
58	1	26	hr. min.

9. Birthplace (City, town, or county): Tenn. 1 (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER
12. Name: James Crammere
13. Birthplace (City, town, or county): Tenn. 1 (State or foreign country)
MOTHER
14. Maiden name: Unknown
15. Birthplace (City, town, or county): Unknown (State or foreign country)
16. (a) Informant: Frank Duckworth
(b) Address: Gashland Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 24. 42 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Pk. Mo.
18. (a) Signature of funeral director: Rose & Henderson
(b) Address: Kansas City Mo.
19. (a) 2/24/42 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 21st year 1942 hour 4 minute 45 A.M.
21. I hereby certify that I attended the deceased from 2-20-42, 19__ to 2-21-42, 19__; that I last saw her alive on 2-21-42, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Ruptured peptic ulcer with acute generalized peritonitis	
Due to: 1 hr.	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: See above	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature: Emery R. Thorn (M. D. or other)
Address: Med. Dir. K.C. Gen. Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 2555

P. O. Address K. C. 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 this body is not embalmed, fact should be so stated above.