

Registration District No. 318

Primary Registration District No.

1. PLACE OF DEATH:

- (a) County St. Louis Mo
 (b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Isolation Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7-3-44 till 24-44
(Specify whether

In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Edhel Duckett

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

- | | | |
|--|--|--|
| 4. Sex <u>M</u> | 5. Color or race <u>C</u> | 6. (a) Single, widowed, married, divorced <u>M</u> |
| 6. (b) Name of husband or wife <u>Normel Duckett</u> | 6. (c) Age of husband or wife if alive _____ years | |
| 7. Birth date of deceased <u>5</u> (Month) | <u>27</u> (Day) | <u>1923</u> (Year) |

- | | | | | |
|---------|-----------------|-----------------|----------------|--|
| 8. AGE: | Years <u>21</u> | Months <u>5</u> | Days <u>27</u> | If less than one day
hr. _____ min. _____ |
|---------|-----------------|-----------------|----------------|--|

9. Birthplace Mississippi (City, town, or county) (State or foreign country) 1

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Hollaway

13. Birthplace Mississippi (City, town, or county) (State or foreign country) 1

14. Maiden name Carrie Buchanan

15. Birthplace Mississippi (City, town, or county) (State or foreign country) 1

16. (a) Informant N. Harris

(b) Address 5600 Arsenal

17. (a) Shuffled (b) Date thereof Nov 29/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jackson Tenn

18. (c) Signature of funeral director J. W. Green

(b) Address 2915 Franklin ave

19. (a) NOV 29 1944 (Date received local registrar) J. J. Brudick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL")
 (d) Street No. 4224 Bought
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 24
 year 44 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from 7-3-44
 _____, 19____, to 11-24-44, 19____

that I last saw her alive on 11-24-44, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Typhoid fever
Pulmonary

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

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 R. W. Maxwell (Dr. Case) (M. D. or other) _____

Address Isolation Hosp. Date signed _____

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

MOTHER FATHER

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..... *J. A. Hean*

Licensed Embalmer No. *2963*

P. O. Address *2915 Franklin ave*

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.