S. No. 2
M—1/47
. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28995

Registration District No. FILED SEP 2 1948

Primary Registration District No. 1003

Registrar's No. 7828

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

1. PLACE OF DEATH:
(a) 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: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 132 Rankin Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Thomas Duncan
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race Col.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Roberta
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 9 (Day) 1886 (Year)

8. AGE: Years 61 Months 5 Days 5 If less than one day hr. min.

9. Birthplace Illinois (City, town, or county) (State or foreign country)
10. Usual occupation Nil
11. Industry or business
FATHER
12. Name Thomas Duncan
13. Birthplace Ill. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Belle Wheller
15. Birthplace Illinois (City, town, or county) (State or foreign country)
16. (a) Informant Roberta Duncan
(b) Address 132A Rankins Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-47 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood
18. (a) Signature of funeral director Bennie Lone
(b) Address 3103 Washington Ave
19. (a) AUG 18 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 14 year 1947 hour 4 minute A M.

21. I hereby certify that I attended the deceased from Aug. 11, 1947 to Aug. 14, 1947; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bilateral Lobar Pneumonia	Undet.
Due to	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy No

PHYSICIAN
Underline the cause of 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 James Whittier (M. D. or other)
Address 2601 N Whittier Date signed 8/14/47

Jefferson City Printing Co.

(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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.