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. 28998

FILED SEP 8 1947

Registration District No. 318 Primary Registration District No. 1002 Registrar's No. 3224

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

**1. PLACE OF DEATH:**

(a) County

(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: Infirmary Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7/15/47 to 8/14/47 (Specify whether In this community years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County 000

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17

(d) Street No. 2530 N. Market St. (If rural, give location) 9

(e) Citizen of foreign country? 20 (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME JOSEPH H. DUVALL

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 Widower

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased July (Month) 2 (Day) 1865 (Year)

8. AGE: Years 82 Months 1 Days 12 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 Harrison Duvall
13. Birthplace Illinois (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mallie Sissell
15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant City Infirmary Records
(b) Address 5800 Arsenal St.

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 8-20-47 (Month) (Day) (Year)
(c) Place: burial or cremation Washington C

18. (a) Signature of funeral director W Kirby
(b) Address 3500 Kirby St

19. (a) AUG 29 1947 (Date received local registrar) (b) J. F. Bledick (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug day 14 year 1947 hour 5 minute 20 P.M.

21. I hereby certify that I attended the deceased from July 15, 1947 to Aug 14, 1947 that I last saw him alive on Aug 14, 1947 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Bronchopneumonia | |
| Due to Hypertensive Cardiovascular Dis. | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

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 0

23. Signature Warren C. Lewis M.D. (M. D. or other)

Address 5600 Arsenal Date signed 8-16-47

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.....

Licensed Embalmer No.....

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. fact should be so stated above.