

15127

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED MAY 8 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 915

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>[REDACTED]</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Koch, Mo</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (In this place) <b>13 1/2 mos.</b>		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>2031 Park</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Walter</b> b. (Middle) <b>F.</b> c. (Last) <b>Duncan</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>4 3 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>7-19-01</b>
9. AGE (In years last birthday) <b>54</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Varied</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Quitman, Arkansas</b>	
		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>Louis Duncan</b>	13b. MOTHER'S MAIDEN NAME <b>Mattie (?)</b>	14. NAME OF HUSBAND OR WIFE <b>Nelda Duncan</b>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>486-18-9225</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Records Koch Hospital, Koch, Mo.</b>	ADDRESS _____
--	--	---	---------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Pulmonary Tuberculosis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>3-6-56</b>	19b. MAJOR FINDINGS OF OPERATION <b>Left upper lobectomy Tuberculosis/theraceoplasty</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--------------------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 2-19, 19 54 to 4-3, 19 56, that I last saw the deceased alive on 4-2, 19 56, and that death occurred at 1:58a m., from the causes and on the date stated above.

23a. SIGNATURE <b>H.A. Harris</b> (Degree or title) <b>MD</b>	23b. ADDRESS <b>Koch Hospital, Koch, Mo</b>	23c. DATE SIGNED <b>4-3-56</b>
---	---	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>4-4-1956</b>	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) <b>Portageville Missouri</b>
--	---------------------------	--	--

DATE REC'D BY LOCAL REG. <b>4-4-56</b>	REGISTRAR'S SIGNATURE <b>Hebert K. Nornberg</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>McLaughlin F.H., Inc., 2301 Lafayette</b>	ADDRESS _____
--	---	---	---------------

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

**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 ....., Student Embalmer No. .... working under my personal supervision.

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 36

P. O. Address 2301

**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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.  
If this body is not embalmed, fact should be so stated above.