

DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 43 8 2 6

FILED VS DEC 21 1959

Registration District No. 15-114 Primary Registration District No. 30-20 Registrar's No. 266

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington MO.</u>		Length of stay in 1b <u>3 Wks.</u>	c. CITY OR TOWN <u>ST. CLAIR</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>ST. CLAIR</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>FRANKLIN</u> Last <u>Dulworth</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/1892</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>	IF UNDER 24 HR Hours <u>4</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ST. CLAIR CITY WATERWORKS DEPT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	11. BIRTHPLACE (City and state or country) <u>JADWIN MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>JOHN W. DULWORTH</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH SMITH</u>		14. NAME OF HUSBAND OR WIFE <u>ALTO ^{NEE} JADWIN DULWORTH</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mildred Young St. Clair Mo</u> Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Respiratory failure</u>	<u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral vascular accident</u>	<u>10 days</u>
	DUE TO (c) <u>Arteriosclerosis</u>	<u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour <u>---</u> Month, Day, Year <u>---</u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>Dec 10, 1959</u> to <u>Dec 11, 1959</u> and last saw her/him on <u>Dec 11, 1959</u> Death occurred at <u>2:30 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>George A. Richardson, M.D.</u>		22b. ADDRESS <u>Medical Arts Clinic Union, Mo</u>	22c. DATE SIGNED <u>Dec 11, 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Dec 14 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. CLAIR MO</u>
24. FUNERAL DIRECTOR <u>Shemond W. Kitchell St. Clair Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12/14/59</u>	26. REGISTRAR'S SIGNATURE <u>F.P. [Signature]</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Sherwood W. Kitchell

Licensed Embalmer No. 3873

P. O. Address St. Clair,

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.