

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-029879

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7488

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 25 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Little Flower Conv. Home.		d. STREET ADDRESS (If outside, give location) 2500 S. 18th Street	
3. NAME OF DECEASED (Type or print) First Middle Last William H. Duckworth		4. DATE OF DEATH Month Day Year July 20, 1963	
5. SEX Male	6. COLOR OR RACE Cau.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-22-74
9. AGE (last birthday) 88		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Credit Manager		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Indiana
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME William G. Duckworth	
13b. MOTHER'S MAIDEN NAME Elizabeth Burlison		14. NAME OF HUSBAND OR WIFE Stella (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Mrs. Grace Wolff 869 Melvin (37)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease - Failure</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>4200</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Hypostatic pneumonia</i>			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 Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 <i>8-11-55</i> to <i>7-20-63</i> and last saw ^{him} alive on <i>7-19-63</i> Death occurred at <i>10:05 a.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Henry Cooper M.D.</i>		22b. ADDRESS <i>H 8 Olive St St. Louis, Mo</i>	22c. DATE SIGNED <i>7/20/63</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>July 22, 63</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Miller Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Mt. Vernon, Indiana</i>
24. FUNERAL DIRECTOR ADDRESS <i>McLaughlin 2301 Lafayette Ave. St. Louis 4, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>JUL 22 1963</i>	26. REGISTRAR'S SIGNATURE <i>Good Smith, M.D.</i>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

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Rev. 4/59
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USE BLACK INK OR TYPEWRITER RIBBON

86

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 James R. Chapman
Licensed Embalmer No. 4550
P. O. Address St. Louis, Mo

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.