

APR 12 1966

NORTH CAROLINA STATE BOARD OF HEALTH  
OFFICE OF VITAL STATISTICS

## CERTIFICATE OF DEATH

7349

REGISTRATION DISTRICT NO. 11.95 REGISTRAR'S CERTIFICATE NO.

This is a legal record and will be permanently filed. Type or write legibly. Use black ink.

The Funeral Director, or person acting as such, is responsible for filling the completed certificate with registrar of the district where death occurred.

The physician last in attendance is required to state the cause of death and sign the medical certification

1. PLACE OF DEATH a. COUNTY Buncombe		b. TOWNSHIP Life		c. LENGTH OF STAY (In 1s) Life		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE North Carolina		b. COUNTY Buncombe	
d. CITY OR TOWN Asheville		Is Place of Death Within City Limits? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		c. CITY OR TOWN Asheville		Is Place of Residence In City Limits? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		On a Farm? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION DOA Memorial Mission Hospital						d. STREET ADDRESS or R. F. D. NO. 127 Pearson Drive			
3. NAME OF DECEASED (Type or Print) First ARTHUR		Middle WALTER		Last DUCKETT		4. DATE OF DEATH Month March		Day 7	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1902		9. AGE (In years last birthday) 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Asheville Fire Dept.		11. BIRTHPLACE (State or foreign country) Buncombe Co. N. C.		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME Walter Duckett			14. MOTHER'S MAIDEN NAME Mary Gallion			NAME OF HUSBAND OR WIFE Mildred Lunsford Duckett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 244-72-1564			17. INFORMANT'S NAME AND ADDRESS Asheville, N. C. Mrs. Mildred Duckett 127 Pearson Dr.			
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>Coronary occlusion, due to</i> ANTECEDENT CAUSES—Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <i>Coronary thrombosis.</i> DUE TO (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>4201</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME MONTH, DAY, YEAR HOUR OF INJURY 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 OR TOWNSHIP COUNTY STATE	
21. I attended the deceased from ..... 19..... to ..... 19..... and last saw her/him alive on ..... 19..... Death occurred at <i>4:30 P.M.</i> on the date stated above and to the best of my knowledge from the causes stated.									
22a. SIGNATURE <i>Herboryn W. T. Crover</i>				22b. ADDRESS <i>Asheville, N. C.</i>		22c. DATE SIGNED <i>3-8-66</i>			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 9, 1966		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		23d. LOCATION (City, town, or county) Buncombe Co.		(State) N. C.	
24. DATE REC'D BY LOCAL REG. <i>3-9-66</i>		25. REGISTRAR'S SIGNATURE <i>P.P. Groce</i>		26. FUNERAL HOME ADDRESS P.P. Groce Funeral Home Inc. Asheville, NC					

MEDICAL CERTIFICATION

THIS COPY FOR STATE BOARD OF HEALTH

Fun. Director's Signature  
License #  
Embalmer's Signature  
License #  
Form 9A Issued

Date Burial Permit Issued  
*3-9-66*  
Date Form 8  
Rev. 1-62  
7-63 100M