F.S. No. 300
REV. 10.48

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

FILED NOV 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37221

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4577

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (in this place): 9 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hospital No. 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson 48
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City 3
d. STREET ADDRESS (If rural, give location): 3110 Woodland 52 5

3. NAME OF DECEASED (Type or Print): a. (First) David b. (Middle) c. (Last) Dingman
4. DATE OF DEATH: (Month) 10 (Day) 25 (Year) 1949
5. SEX: M 0
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widower 2
8. DATE OF BIRTH: 4-17-1874 Oct. 25, 1949
9. AGE (In years last birthday): 75 | 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): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Iowa 1
12. CITIZEN OF WHAT COUNTRY? US
13a. FATHER'S NAME: unknown
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: Iva May Dingman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: --
17. INFORMANT'S SIGNATURE OR NAME: Cleo W. Dingman ADDRESS: 3110 Woodland

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH

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.

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19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

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) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-25, 1949, *to* 10-25, 1949, *that I last saw the deceased alive on* Oct. 25, 1949, *and that death occurred at* 12:25A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Wm. W. Hart (Degree or title) MD 0
23b. ADDRESS: Med. Dir. Gen'l Hosp.
23c. DATE SIGNED: 10-25-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/27/49
24c. NAME OF CEMETERY OR CREMATORY: –
24d. LOCATION (City, town, or county) (State): Cowgill, Mo.

DATE REC'D BY LOCAL REG.: 10-27-49
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: STINE & MCCLURE CO. KANSAS CITY MO.

(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 .....

..... Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed E. M. Plank

Licensed Embalmer No. 1848

P. O. Address K. C. 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 this body is not embalmed, fact should be so stated above.