

FILED JUN 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14515

State File No.

BIRTH NO. 278.37-55 REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 161

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Macon	
b. CITY OR TOWN Kirksville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Elmer	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Kirksville Osteopathic Hospital		d. STREET ADDRESS (If rural, give location) Box 178	

3. NAME OF DECEASED (Type or Print) a. (First) Willetta b. (Middle) Ann c. (Last) Duggins			4. DATE OF DEATH (Month) (Day) (Year) June 7 55		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH June 6, 1955		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Min. 24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? US					

13a. FATHER'S NAME Alfred Benjamin Duggins		13b. MOTHER'S MAIDEN NAME Wanda Dean Haney		14. NAME OF HUSBAND OR WIFE	
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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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wanda H. Duggins	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral anoxia Medullary failure		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		DUE TO (b) Cerebral anoxia			
		DUE TO (c) Atelectasis.			
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 7620		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) (Min.)		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 June 6, 1955, to June 7, 1955, that I last saw the deceased alive on June 6, 1955 and that death occurred at 12:05 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. O. Reemore, D.O.		23b. ADDRESS 1001 Kirksville, Mo.		23c. DATE SIGNED 6-7-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 8 1955		24c. NAME OF CEMETERY OR CREMATORY Elmer	
				24d. LOCATION (City, town, or county) (State) Elmer Macon County MO	

DATE REC'D BY LOCAL REG. 6-13-55		REGISTRAR'S SIGNATURE Kate Lambert		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. H. McCallum South Gifford MO	
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WRITE PLAINLY—USING UNFAADING 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.

Signed.....
W. McCallum

Signed.....
Student Embalmer

Licensed Embalmer No. 2052

P. O. Address..... South Gifford 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.