

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41444  
STATE FILE NUMBER  
5411  
Registror's No.

FILED JAN 14 1957

Registration District No. 149 Primary Registration District No. 1002

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 300 -56  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms or signs of natural causes. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 John R. Whiteman

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp. - Obergday</b>			Length of stay in lb	d. STREET ADDRESS <b>201 Porte Cima PAS.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>M.</b> Last <b>DUGAN</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>13</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1903 Dec 29, 1904</b>		9. AGE (In years last birthday) <b>52</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Resturant owner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Resturant</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John D. Dugan</b>				14. MOTHER'S MAIDEN NAME <b>Agnes O'Leary</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO.</b>		16. SOCIAL SECURITY NO. <b>493-22-8284</b>		17. INFORMANT <b>MRS. LEORNA DUGAN</b> Address <b>201 Porte Cima PAS.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured dissecting Aneurysm ascending aorta, arterioelucte</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____		DUE TO (c) _____		451X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>12-13-56</b> to <b>12-13-56</b> and last saw <del>her</del> him alive on <b>12-13-56</b> Death occurred at <b>10:30 AM.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>John R. Whiteman MD</b> (Degree or title)				22b. ADDRESS <b>6314 Brookside Plaza</b>		22c. DATE SIGNED <b>12-14-56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Dec. 15, 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>		
24. FUNERAL DIRECTOR <b>Muehleback</b>		ADDRESS <b>6800 TROOST</b>		25. DATE RECD. BY LOCAL REG. <b>12-14-56</b>		26. REGISTRAR'S SIGNATURE <b>Neval Minshall</b>	

APR 11 1958

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7414-6607

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.....  
*Richard E. Nichol*

Licensed Embalmer No. *499*

P. O. Address *6702 1/2  
Keweenaw City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (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.