Health, & Welfare Public Service

S. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-017048
STATE FILE NUMBER

FILED MAY 26 1959 Registration District No. 61 Primary Registration District No. 4107 Registrar's No. 24

1. PLACE OF DEATH
a. COUNTY Cedar
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN El Dorado Springs — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 309 N. Grand — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Cedar
c. CITY OR TOWN El Dorado Springs — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 309 N. Grand — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First THOMAS Middle C. Last DUGGER
4. DATE OF DEATH Month Day Year 5-18-59
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH April 23, 1884
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 Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Republic co., Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John Dugger
13b. MOTHER'S MAIDEN NAME Annie Ward
14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO.
17. INFORMANT Maud Zug Address El Dorado Spgs., Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cor Pulmonale
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Decompensating heart
DUE TO (c) Arteriosclerotic heart disease
INTERVAL BETWEEN ONSET AND DEATH: 3 mo years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 3-20-59, to 5-18-59 and last saw ~~her~~ him alive on 4-17-59
Death occurred at 10 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C H Sunderwirth DO
22b. ADDRESS El Dorado Spgs.
22c. DATE SIGNED 5-19-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 5-20-59
23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery
23d. LOCATION (City, town, or county) (State) Bellville, Kansas

24. FUNERAL DIRECTOR ADDRESS Gwinn-Carother-ElDorado Spgs., Mo.
25. DATE RECD. BY LOCAL REG. 5-19-59
26. REGISTRAR'S SIGNATURE George W. Nofer

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

JUN 22 1955

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 Max W. Dickering

Licensed Embalmer No. 7696

P. O. Address El Dorado Sp

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.