

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-031204

STATE FILE NUMBER

FILED VS SEP 14 1959

Registration District No. 337 Primary Registration District No. _____ Registrar's No. 71

1. PLACE OF DEATH a. COUNTY <u>SHEBBY</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SHEBBY</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SHEBBYVILLE, MO.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>SHEBBYVILLE, MO.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PLEASANT HILL-REST</u>		Length of stay in 1b <u>4 years</u>	d. STREET ADDRESS (If outside, give location) <u>SHEBBYVILLE, MO.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>HENRY</u> Last <u>TUGGHE</u>			4. DATE OF DEATH Month <u>SEPT</u> Day <u>8</u> Year <u>1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JAN 6, 1926</u>	9. AGE (In years last birthday) <u>33</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAXI CAB DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL LABORER</u>		11. BIRTHPLACE (City and state or country) <u>SHEBBY COUNTY - MO.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>RICHARD H. TUGGHE</u>		13b. MOTHER'S MAIDEN NAME <u>MARY E. PEOPLES</u>	
14. NAME OF HUSBAND OR WIFE <u>BERTHA ANN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>491-20-9666</u>	
17. INFORMANT <u>DONALD TUGGHE - TERRE HAUTE</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma of Pancreas</u> DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>157X</u>		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 _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <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 <u>Shebbville, Mo</u>		COUNTY _____ STATE _____		21. I attended the deceased from <u>Jan 15 1959</u> to <u>Sept 8 1959</u> and last saw ^{her} him alive on <u>Sept 7, 1959</u> Death occurred at <u>6 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>G.W. Mansland Doc I</u>		22b. ADDRESS <u>Shebbville, Mo</u>		22c. DATE SIGNED <u>9-8-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE <u>SEPT 9, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEWCOMER'S CREMATORY</u>	
23d. LOCATION (City, town, or county) <u>KANSAS CITY, MO.</u>		23e. STATE <u>MO.</u>		24. FUNERAL DIRECTOR <u>GREENING - SHEBBYVILLE, MO.</u>	
25. DATE RECD. BY LOCAL REG. <u>9-9-59</u>		26. REGISTRAR'S SIGNATURE <u>Ada Garrison</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
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.

419-6

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 *Charles P. Freeman*

Licensed Embalmer No. *4625*

P. O. Address *Clarence*

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.