

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1003

-61-030696

AMENDED

Registration District No. 318

Primary Registration District No.

Registrar's No. 7641

STATE FILE NUMBER

FILED AUG 23 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,		c. CITY OR TOWN St. Louis,	
Length of stay in lb		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros Hosp.		d. STREET ADDRESS (If outside, give location) 4115 Wyomong Str.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE A. DUGGAN			4. DATE OF DEATH Month Day Year Aug. 15th, 1961			
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1889	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Copy Editor*Retd.	10b. KIND OF BUSINESS OR INDUSTRY Globe Democrat	11. BIRTHPLACE (City and state or country) Jerseyville, Ill.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Patrick Duggan	13b. MOTHER'S MAIDEN NAME Ellen Doherty	14. NAME OF HUSBAND OR WIFE Mae X. Duggan
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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 None	17. INFORMANT Mae X. Duggan-4115 Wyoming Str.
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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>Cerebral apoplexy</u> DUE TO (b) <u>arteria sclerosis</u> DUE TO (c) <u>334X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 hrs</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from <u>8/17/61</u> to <u>8/15/61</u> and last saw him alive on <u>8-15-61</u> Death occurred at <u>10:10 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Mustard Glasser M.D.</u> (Degree or title)	22b. ADDRESS <u>500 Olive St.</u>	22c. DATE SIGNED <u>8/17/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 18, 1961	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Mo.
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24. FUNERAL DIRECTOR Kriegshauser-4228 S.Kingshighway Blvd.	25. DATE RECD. BY LOCAL REG. AUG 17 1961	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF)

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 William B White

Licensed Embalmer No. 4281

P. O. Address _____

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.