

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-039875

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5778 STATE FILE NUMBER

FILED NOV 7 1963

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jackson		a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 40 yrs.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4441 Belfontaine		d. STREET ADDRESS (If outside, give location) 4441 Belfontaine	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) JOHN B. DUGGINS			4. DATE OF DEATH October 25, 1963		
First Middle Last			Month Day Year		

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1860	9. AGE (last birthday) 103	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner & Farmer	10b. KIND OF BUSINESS OR INDUSTRY same	11. BIRTHPLACE (City and state or country) Lexington, Missouri	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME William Duggins	13b. MOTHER'S MAIDEN NAME Mary Jones	14. NAME OF HUSBAND OR WIFE Anna Duggins
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) [REDACTED]	17. INFORMANT Address Mrs. Catherine Withas - 4441 Belfontaine
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18. CAUSE OF DEATH (Enter only one cause per line)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		5 yrs.
IMMEDIATE CAUSE (a) Atherosclerosis		
DUE TO (b) _____		
DUE TO (c) _____		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

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
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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 Aug. 15 '63 to Oct 25 '63 and last saw ^{them} him alive on Oct. 22 '63
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Alfred A. Caruso M.D.	22b. ADDRESS 924 - Linwood	22c. DATE SIGNED 10/25/63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-28-63	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) Corder, Missouri
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24. FUNERAL DIRECTOR ADDRESS Mellody-McGilley-Eylar Funeral Home Linwood & WOODLAND	25. DATE RECD. BY LOCAL REG. 10-25-63	26. REGISTRAR'S SIGNATURE Bessie Smith
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(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	BY AFFIDAVIT OF	MEDICAL CERTIFICATION
1						
2	<u>3618</u>					
3						
4	<u>0</u>					
5	<u>2</u>					
6						
7	<u>0</u>					
8	<u>2</u>					
9	<u>4500</u>					
10						
11						
12	<u>90-0</u>					
13						

USE BLACK INK OR TYPEWRITER RIBBON

Alfred A. Caruso

Dr. Caruso
924 Linwood
JE 1-2141

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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 _____

Licensed Embalmer No. _____

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.