

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1057

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 26 days  
In this community SAME  
years, months or days) (Specify whether

3. (a) PRINT FULL NAME DUGGINS--John Vincent 525

3. (b) If veteran, No name war. 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. years

7. Birth date of deceased. February 9, 1940  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
-- -- 28 hr. min.

9. Birthplace. Kansas City, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation. Infant

11. Industry or business

MOTHER FATHER { 12. Name Carroll Joseph Duggins

18. Birthplace Corder, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Eva Murphy Duggins

15. Birthplace Montreal, Canada  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Carroll J. Duggins

(b) Address 135 So. Oxford

17. (a) Burial (b) Date thereof Mar. 8, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
St. Mary's Cem.

(c) Place: burial or cremation Shell Funeral Home

18. (a) Signature of funeral director City

(b) Address City

19. (a) Mch 7, 1940 (b) M. M. Browne  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City Mr Wash, Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 135 So. Oxford  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6th  
year 1940 hour 9 minute 45 A. M.

21. I hereby certify that I attended the deceased from 2-9-40, 19\_\_\_\_, to 3-6-40, 19\_\_\_\_;

that I last saw him alive on 3-6-40, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Streptococcic septicemia with multiple abscesses

Due to 36

Due to

Other conditions Bilateral hydronephrosis  
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy See above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature A. J. De Maria MD (M. D. or other)  
Supt. K.C. Gen. Hospital, K.C. Mo.  
Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

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 this body is not embalmed, above space should be left blank.**