

3. No. 2
-1-4-41
5-17-39
PI X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **2070**
Registrar's No. **44**

Registration District No. **24/ab**

Primary Registration District No. **5338-5349**

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

1. PLACE OF DEATH:

(a) County **Dallas**
(b) City or town **Windyville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Dallas**
(c) City or town **RURAL**
(If outside city or town limits, write "RURAL")
(d) Street No. **Windyville Mo**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **William Peter Dugan**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **8** day **31**
year **1942** hour **8** minute **7** M.

4. Sex **M** 5. Color or Face **W**
6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife **Mattie** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **2 26 1876**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 14** 19**42** to **August 31** 19**42**
that I last saw him alive on **August 24** 19**42**
and that death occurred on the date and hour stated above.

8. AGE: Years **66** Months **6** Days **5** If less than one day _____ hr. _____ min.

Immediate cause of death **Coronary Sclerosis**
Due to **Generalized Arteriosclerosis**

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

Due to _____
Other conditions _____ (Include pregnancy within 8 months of death)

10. Usual occupation **Farmer**
11. Industry or business _____
MOTHER FATHER { 12. Name **Theodore Dugan**
13. Birthplace **Unknown** (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mattie Dugan**
(b) Address **Windyville Mo**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9-1-42** (Month) (Day) (Year)
(c) Place: burial or cremation **Cedar Ridge**
18. (a) Signature of funeral director **L. B. Jones**
(b) Address **Buffalo Mo**
19. (a) **9/1/42** (Date received local registrar) (b) **John Darnin** (Registrar's signature)

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 **John Darnin** (M. D. or other) **D.O.**
Address **Buffalo, Mo** Date signed **9/1/42**

1089 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7.
District No. 12-42-1876
Date Recd. 1-12-43

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 *Clyde Montgomery*
Licensed Embalmer No. *3592*
P. O. Address *Buffalo, Mo.*

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, fact should be so stated above.