

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 903

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

**1. PLACE OF DEATH:**

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
1206 - Sixth Ave!  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community about 50 yrs.  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 1206 - Sixth Ave. 7  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** WILLIAM ANDREW DOUGAN

3. (b) If veteran, name war No

3. (c) Social Security No. 491-09-0383

4. Sex Male 5. Color or race Wht

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Effie

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Aug. 9 1881  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug day 8 year 1946 hour 2:30 minute a. M.

21. I hereby certify that I attended the deceased from June 15, 1946 to August 5, 1946.  
that I last saw him alive on August 5, 1946,  
and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
<u>64</u>	<u>11</u>	<u>29</u>	hr. _____ min. _____

Immediate cause of death Cerebral Embolism Duration 4 days.

Due to Hepatic Cirrhosis 13 years

Chronic Myocarditis ?

Due to Chronic Hypertension ?

9. Birthplace Bald Knob Mo!  
(City, town, or county) (State or foreign country)

10. Usual occupation Employed

11. Industry or business Buchanan County

MOTHER, FATHER { 12. Name James Oliver Dougan

13. Birthplace Ind.  
(City, town, or county) (State or foreign country)

14. Maiden name Belle Duffey

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

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations None 1248

Of autopsy None

**PHYSICIAN**  
\_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant: Mrs. Vera Dougan - Adams

(b) Address St. Joseph Mo

17. (a) B. (b) Date thereof 8-10-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cem.

18. (a) Signature of funeral director Clayton Funeral Home

(b) Address St. Joseph Mo

19. (a) Aug. 13, 1946 (b) W. A. Whitman  
(Date received local registrar) (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? \_\_\_\_\_

(Specify type of place)

While at work? No (e) Means of injury \_\_\_\_\_

23. Signature H. S. Linnard (M. D. or other) \_\_\_\_\_  
Address 404 Tootle Bldg. St. Joseph, Date signed 8-8-46

AUG 28 1946

FEB 5 1947

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..... *John Roy Cloney*  
Licensed Embalmer No..... *2435*  
P. O. Address..... *Al Joseph*

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.