

FILED AUG 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26631

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 741

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Springfield Baptist Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>716 State St.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Marionie</u> b. (Middle) <u>Dean</u> c. (Last) <u>Kukul</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 18 1949</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 14, 1927</u>
9. AGE (In years last birthday) <u>21</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>housework</u>
11. BIRTHPLACE (State or foreign country) <u>Bolivar Mo. II</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Clayton G. Teegarden</u>		13b. MOTHER'S MAIDEN NAME <u>Lorene Ferris</u>	
14. NAME OF HUSBAND OR WIFE <u>Miles Kukul</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Miles Kukul</u> ADDRESS <u>716 State St. Springfield Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Adipicari Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> ANTECEDENT CAUSES *Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Adrenal Cortical Insufficiency</u> <u>2 years</u> DUE TO (c) <u>274X</u> 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pregnancy, Uterine, 6 mo. Spontaneous abortion</u> <u>1 day</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u> m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/1</u> , 19 <u>47</u> , to <u>8/18</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8/18</u> , 19 <u>49</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>William D. Dark M.D.</u> (Degree or title)		23b. ADDRESS <u>Professional Bldg. Springfield, Missouri</u>	
23c. DATE SIGNED <u>8/18/49</u>		24. LOCATION (City, town, or county) (State)	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>August 21, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Bolivar, Missouri</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>8-20-49 W.F. Audley M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Turpin Funeral Home Bolivar, Mo.</u>		

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

FEB 18 1950

OCT 25 1949

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
Student Embalmer

Signed _____

Licensed Embalmer No. 3053

P. O. Address Bolivar, 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.