

FILED JAN 23 1950

THE DIVISION OF HEALTH OF MISSOURI,
STANDARD CERTIFICATE OF DEATH

State File No. 791

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 3000 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		0396	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John Hosp.		d. STREET ADDRESS 1501 University		0	

3. NAME OF DECEASED (Type or Print)		a. (First) John		b. (Middle) A.		c. (Last) Doggrell		4. DATE OF DEATH (Month) (Day) (Year)		Jan. 20, 1950	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Aug. 6 1876		9. AGE (In years last birthday) 73		IF UNDER 1 YEAR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Frisco R.R.		11. BIRTHPLACE (State or foreign country) Ellis Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Frank Doggrell		13b. MOTHER'S MAIDEN NAME Elizabeth O'Toole		14. NAME OF HUSBAND OR WIFE X	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT'S SIGNATURE OR NAME Mrs. Jane Hershey Hollister, Mo.		ADDRESS	
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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				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Sclerosis		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Prostatic Hypertrophy		5 yrs.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c)				4 yrs.	

19a. DATE OF OPERATION 1-18-50		19b. MAJOR FINDINGS OF OPERATION Prostatic Hypertrophy		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE SUICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 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 1-1-1950, to 1-18, 1950, that I last saw the deceased alive on 1-18, 1950, and that death occurred at 2a m., from the causes and on the date stated above.

23a. SIGNATURE Robert W. Hayward M.D.		(Degree or title)		23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 1-20-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan. 21, 1950		24c. NAME OF CEMETERY OR CREMATORY Maple Park		24d. LOCATION (City, town, or county) (State) Springfield, Mo.	

DATE REC'D BY LOCAL REG. 1-20-50		REGISTRAR'S SIGNATURE W. E. Hays		25. FUNERAL DIRECTOR'S SIGNATURE H.H. Lohmeyer		ADDRESS Springfield, Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

JAN 27 1950

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.

Signed Robert M. Dew

Signed.....
Student Embalmer

Licensed Embalmer No. 4732

P. O. Address Longfield, 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.