

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Statr File No. 7296

C-# UNK FILED MAR 2 1954
Reg. 116,778

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 431

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE ILLINOIS b. COUNTY MADISON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFFERSON BARRACKS, MO.		c. LENGTH OF STAY (In this place) 7 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS (If rural, give location) BOX 255	

3. NAME OF DECEASED (Type or Print) STILLWELL	a. (First) F.	b. (Middle) DUGGER	c. (Last) 2-16-54	4. DATE OF DEATH (Month) (Day) (Year)
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 3-5-1902	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 15 Min. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY UNK.	11. BIRTHPLACE (State or foreign country) COLLINSVILLE, ILLINOIS /	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME BERT A. DUGGER	13b. MOTHER'S MAIDEN NAME NEIL C. KINCAID	14. NAME OF HUSBAND OR WIFE MARY MARIE DUGGER
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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) YES WW-II	16. SOCIAL SECURITY NO. 49212 6481	17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS, JEFF. BRKS. MO.	ADDRESS
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) MEDICAL CERTIFICATION CORONARY THROMBOSIS	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 8 HOURS
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4201
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **2-9-54**, 19**54**, to **2-16-54**, 19**54**, and that death occurred at **1:40 pm.**, from the causes and on the date stated above.

23a. SIGNATURE <i>Stanley S. Brown, M.D.</i>	(Degree or title) M.D. VA HOSP., JEFF. BRKS., MO.	23b. ADDRESS	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 2-16-54	24c. NAME OF CEMETERY OR CREMATORY FRIEDENS	24d. LOCATION (City, town, or county) (State) TROY ILLINOIS
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DATE REC'D BY LOCAL REG. 2-16-54	REGISTRAR'S SIGNATURE <i>Herbert R. Donke M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel S. Edwards</i>	ADDRESS Troy, Ill.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Jewel L. Edwards

Signed.....
Student Embalmer

Licensed Embalmer No. 3548

P. O. Address Irving, Ill

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.