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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36818**

FILED NOV 29 1955

BIRTH NO. **10603 64806-55** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **4885**

1. PLACE OF DEATH a. COUNTY <b>Jackson Co.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johanna</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>		c. CITY OR TOWN <b>Owland Park</b>	
c. LENGTH OF STAY (in this place) <b>Life</b>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b>		STREET ADDRESS (If rural, give location) <b>7233 Lamar</b>	

3. NAME OF DECEASED (Type or Print) <b>Lawrence Edward Duggin</b>			4. DATE OF DEATH <b>Nov-11-55</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <b>never married</b>	8. DATE OF BIRTH <b>Sept 3-55</b>	9. AGE (In years last birthday) <b>2</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>8</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Kansas City, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>

13a. FATHER'S NAME <b>Wm. E. Duggin</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Walters</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mr. William E. Duggin (Father)</b>	

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, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>congenital heart disease, cyanotic type</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	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 checked="" type="checkbox"/> NO <input type="checkbox"/>	
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)	
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?	

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <b>David M. Gibson</b> (Degree or title) <b>0</b>		23b. ADDRESS <b>St. Luke's Hospital /c/ no.</b>		23c. DATE SIGNED <b>11/11/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Nov. 12 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cem.</b>	
		24d. LOCATION (City, town, or county) <b>Kansas City, Kansas</b>		(State)	

DATE REC'D BY LOCAL REG. <b>11-12-55</b>		REGISTRAR'S SIGNATURE <b>Neva Marshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Funeral Home</b>	
				ADDRESS <b>KCK</b>	

WRITE PLAINLY—USING UNFADEING 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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Max E. Meyer*

Licensed Embalmer No. *45*

P. O. Address *K. E. Ke*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.