

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009371

STATE FILE NUMBER

FILED APR 8 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1502

300
-57

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.
Frank Paul Laurenzana

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION K. C. Nursing Home		Length of stay in lbs 7 yrs	d. STREET ADDRESS (If outside, give location) 3200 Norledge		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last GRACE DUGAN			4. DATE OF DEATH Month Day Year March 22 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1875	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Atchison Co., Ks.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Thomas Dugan		13b. MOTHER'S MAIDEN NAME Mary Jane Brooks		14. NAME OF HUSBAND OR WIFE Oliver Dugan	
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. No	17. INFORMANT Address Mrs. Ruth Keiser, 3200 Norledge		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> DUE TO (b) <i>Carcinoma of Skin on Face</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1912					INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>3 years</i>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>1-1-59</i> to <i>3-22-59</i> and last saw her alive on <i>3-22-59</i> Death occurred at <i>6:00</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Frank Paul Laurenzana MD</i>		22b. ADDRESS <i>428 S. White Ave</i>		22c. DATE SIGNED <i>3-22-59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>3-23-1959</i>		23c. NAME OF CEMETERY OR CREMATORY <i>-</i>	
23d. LOCATION (City, town, or county) <i>Leavenworth, Kansas</i>			23e. (State)		
24. FUNERAL DIRECTOR <i>Mellody-McGilley-Eylar Funeral Home</i> <i>Woodland-Linwood</i>			25. DATE RECD. BY LOCAL REG. <i>3-23-59</i>		26. REGISTRAR'S SIGNATURE <i>Sherril Minshall</i>



J. Paul Law
Memphis, Tenn.
Be 1-3319
11-3 PM

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 *James W. Wair*

Licensed Embalmer No. *4650*

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