

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037111

LED VS SEP 26 1960

322

Registration District No. _____ Primary Registration District No. 3071

Registrar's No. 46

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Saline				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Saline				
b. CITY (If outside corporate limits, give TOWNSHIP only) Slater		Length of stay in lb Life		c. CITY OR TOWN Slater		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Emma St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Emma St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MICAJAH Middle CLARENCE Last DUGGINS				4. DATE OF DEATH Month Sept. Day 16 Year 1960				
5. SEX Male	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 8/27/1874	9. AGE (last birthday) 86	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor			10b. KIND OF BUSINESS OR INDUSTRY Medical Doctor		11. BIRTHPLACE (City and state or country) Northwest Slater Mo		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Thomas C. Duggins			13b. MOTHER'S MAIDEN NAME Ann Pulliam			14. NAME OF HUSBAND OR WIFE Virginia Duggins		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, war or dates of service) No None			16. SOCIAL SECURITY NO. 495-36-5895		17. INFORMANT Address J. B. Johnson Slater, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate gland. DUE TO (b) Generalized Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 2-3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 _____ a.m. _____ p.m.		Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <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 July 1-1960 to Sept. 14 and last saw him alive on Sept 14-60. Death occurred at Slater at 1/2 on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE D. Nelson (Degree or title)				22b. ADDRESS 313 1/2 N. Main Slater			22c. DATE SIGNED 9-17-60.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/19/1960	23c. NAME OF CEMETERY OR CREMATORY Slater		23d. LOCATION (City, town, or county) (State) Slater, Missouri.				
24. FUNERAL DIRECTOR Haines Funeral Home Slater, Mo.			25. DATE RECD. BY LOCAL REG. 9-18-60		26. REGISTRAR'S SIGNATURE Mrs. Raymond Beane			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4630

P. O. Address Slater, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.