

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-026702

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 1086

<b>FILED AUG 6 1962</b>		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Greene</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. John's Hospital</u>		Length of stay in lb OR Min. <u>10 Min.</u>		c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		d. STREET ADDRESS (If outside, give location) <u>1901 E Page (parents Address)</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
First <u>MARY</u> Middle <u>MELISSA</u> Last <u>DUGAN</u>		Month <u>JULY</u> Day <u>13</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1962</u>	9. AGE (last birthday) <u>Heart beat for 10</u>	IF UNDER 1 YEAR <u>10</u> IF UNDER 24 HR <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (City and state or country) <u>Springfield, Missouri</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Ralph B Dugan</u>		13b. MOTHER'S MAIDEN NAME <u>Edna Doris Hyde</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Ralph B Dugan, Springfield, Missouri</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
IMMEDIATE CAUSE (a) <u>Anoxia</u>					
DUE TO (b) <u>Extreme prematurity 21 wks gestation</u>					
DUE TO (c) <u>Placental Insufficiency &amp; Premature Labor</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not stated to the terminal disease condition given in PART I (a) <u>Possible overexertion of mother.</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <u>July 13, 1962</u> to <u>July 13, 1962</u> and last saw her live on <u>July 13, 1962</u> Death occurred at <u>July 13, 1962 5:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Ronald M. D.</u> Degree or title		22b. ADDRESS <u>Springfield, Mo</u>		22c. DATE SIGNED <u>7-15-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Held</u>		23b. DATE <u>July 13, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Hospital Laboratory for Pathological Study</u> 23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <u>H.H. LOHMEYER, Springfield, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>7-31-62</u>		26. REGISTRAR'S SIGNATURE <u>Effie &amp; Melton</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

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**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. *This was not embalmed.*

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.