

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-006504

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 570 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 18 1963

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in lb <u>38 yrs</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) <u>328 South Elmwood</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
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| 3. NAME OF DECEASED First Middle Last <u>EDWARD F. DUGGINS</u> | | | 4. DATE OF DEATH Month Day Year <u>Jan 28 1963</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-11-1892</u> | 9. AGE (last birthday) <u>70</u> | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>K. C. Police Dept</u> | | 11. BIRTHPLACE (City and state or country) <u>Lexington, Missouri</u> | | |
| 13a. FATHER'S NAME <u>John B. Duggins</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Anna Carroll</u> | | 14. NAME OF HUSBAND OR WIFE <u>Margaret Duggins</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> <u>WWI</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Margaret A. Duggins, 328 South Elmwood</u> | |

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| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute massive myocardial infarct, week</u> DUE TO (b) <u>Generalized arterial sclerosis, years</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH _____ |
| 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 |

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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ s.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 1-21-63 to 1-29-63 and last saw her/him alive on 1-27-63
 Death occurred at 5:50 AM m. on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|--|---|--|---|--|
| 22a. SIGNATURE (Degree or title) <u>Thos. O. McGilley M.D.</u> | | 22b. ADDRESS <u>4601 Indep. Ave</u> | | 22c. DATE SIGNED <u>1-29-63</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>1-30-1963</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Melody-McGilley-Eylar Funeral Home</u> | | 25. DATE RECD. BY LOCAL REG. <u>1-29-63</u> | | 26. REGISTRAR'S SIGNATURE <u>Ruth Long</u> | |

Woodland-Linwood (Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59
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 230882
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 4 0
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 13
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 ITEM NO.
 BY AFFIDAVIT OF
 THOS. O. MCGILLEY
 MEDICAL CERTIFICATION
 DOCUMENT
 DATE AMENDED
 USE BLACK INK OR TYPEWRITER RIBBON

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 R Phillips

Licensed Embalmer No. 4641

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.