

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

44431

JAN 8 1940

State File No. \_\_\_\_\_

Registration District No. 743

Primary Registration District No. 6237

Registrar's No. 31

1. PLACE OF DEATH:

(a) County Ray  
 (b) City or town Rural - Fishing River  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
4 Mi. East of Excelsior Springs Highway 101  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution Home  
 In this community 8.5 yrs - 4 days  
 (Specify whether years, months or days)

8. (a) PRINT FULL NAME JOSEPH HIGHTOWER

8. (b) If veteran, name war NO  
 8. (c) Social Security No. NO

4. Sex Male  
 5. Color or race white  
 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Wendie Sisk  
 6. (c) Age of husband or wife if alive unknown years  
 7. Birth date of deceased: Nov. 26 1854  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>0</u>	<u>4</u>	hr. min.

9. Birthplace Ray Co. Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farmer

12. Name Thomas Hightower

13. Birthplace Senon, Ray Co. Mo.  
 (City, town or county) (State or foreign country)

14. Maiden name Sally Cleveland

15. Birthplace Ray Co. Mo.  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Gra Segel

(b) Address Ray Co. Mo.

17. (a) Burial  
 (Burial, cremation, or removal) (b) Date thereof Dec. 2, 1939  
 (Month) (Day) (Year)

(c) Place: burial or cremation near garden

18. (a) Signature of funeral director Berbert Hope

(b) Address Excelsior Springs, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray  
 (c) City or town Rural - Fishing River township  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4 Mi. East Excelsior Springs - Highway No. 10  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 30th  
 year 1939 hour 8 minute 10 P. M.

21. I hereby certify that I attended the deceased from Nov. 26, 1939, to Nov. 30, 1939  
 that I last saw him alive on Nov. 26, 1939  
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocardial Infarction  
Pericarditis  
 Duration 10 days

Due to Chronic Arterial Sclerosis  
Atherosclerosis  
 Duration years

Due to ✓  
 Other conditions age 85 years  
 (Include pregnancy within 3 months of death)

Major findings: none performed  
 Of operations \_\_\_\_\_

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

While at work \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature John F. Grace (M. D. or other) MD  
 Address Excelsior Springs, Mo. Date signed 12/1-39

PHYSICIAN  
 Underline the cause to which death should be charged statistically

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE-PHIVERY-USE-ON-ADIRVO-BLACK-INK-MAKE-A-PERMANENT-RECORD

1322

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 \_\_\_\_\_

Herbert Hope, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Herbert Hope

Licensed Embalmer No. 3199

P. O. Address Excelsior Springs, 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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

44431  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Ray Registration District No. 743  
 (b) Township Fishing R. Primary Registration District No. 6237  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Joseph Hightower  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
85 0 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

FATHER  
 13. NAME \_\_\_\_\_  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER  
 15. MAIDEN NAME \_\_\_\_\_  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 30 1937

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:  
acute uremic poison -  
chronic arterial ather-  
sclerosis  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: 1/21  
Chronic nephritis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis?  Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) John F. Grace, M. D.  
 (Address) Specimen Appo mo

SUPPLEMENTARY

Local Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

44431  
Do not use this space.

1. PLACE OF DEATH

(a) County Rain Registration District No. 743  
 (b) Township Fishing River Primary Registration District No. 6237  
 (c) City..... (d) Street No..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Joseph Hightower  
 (a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or ..... min.  
82 0 4

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Dec 2 1940 E. C. Gibson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 30 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19.....  
 I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at..... m.  
 The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury..... 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....  
 If so, specify John F. Essene M. D.  
 (Signed) Inspector of Hygiene  
 (Address) .....

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.