S. No. 2
—11-10-39
. 5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 7 1947

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

33518

State File No.

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 154

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Rural Washington Twp (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No. 3 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 22 Days. (Specify whether years, months or days)

In this community 22 Days.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 108

(c) City or town Carthage Mo. 0 (If outside city or town limits, write "RURAL")

(d) Street No. Rural 0 (If rural, give location)

(e) If foreign born, how long in U. S. A.? ✓ 0 years.

3. (a) PRINT FULL NAME DILLARD HETHCOAT

3. (b) If veteran, name war D.K.

3. (c) Social Security No. D.K.

4. Sex M O

5. Color or race W

6. (a) Single, widowed, married, divorced D 2

6. (b) Name of husband or wife D.K.

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 5 (Month) 1 (Day) 1880 (Year)

8. AGE: Years 67 Months 4 Days 24 If less than one day hr. min.

9. Birthplace LPK (City, town, or county) LPK 9 (State or foreign country)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name James Hethcoat
13. Birthplace Illinois 1 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Dallas
15. Birthplace Mount Vernon Mo 0 (City, town, or county) (State or foreign country)

16. (a) Informant Records

(b) Address State Hospital.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-47 (Month) (Day) (Year)

(c) Place: burial or cremation Hosp. Cemet.

18. (a) Signature of funeral director Eschenger Funeral Home

(b) Address Nevada, Mo

19. (a) 9-29-47 (Date received local registrar) (b) Kathryn Yancey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 25 year 1947 hour 1030 minute P. M.

21. I hereby certify that I attended the deceased from 9-3-1947, 19 to 9-25-1947 that I last saw him alive on 9-25-1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Senile Deterioration	22 Days +
Due to Generalized Arteriosclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature J R Bunch (M. D. or other)

Address State Hospital #3 Date signed 9-25-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 9-47-1170
Date Filed 10-6-47

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed not by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Marsh. Eichinger

Licensed Embalmer No. 2656

P. O. Address Nevada, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.