

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11622

State File No.

FILED APR 18 1949

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 51290 Registrar's No. 396

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, Platte Twsp.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, Platte Twsp.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3 mile north Dearborn, Mo.		d. STREET ADDRESS (If rural, give location) 3 mile north of Dearborn, Mo.	

3. NAME OF DECEASED (Type or Print)	a. (First) Mamie	b. (Middle) Elizabeth	c. (Last) Hoy	4. DATE OF DEATH (Month) (Day) (Year) April 10 1949
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH August 7, 1891	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days 3	Hours 	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY XX	11. BIRTHPLACE (State or foreign country) Quincey Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Stephens	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Joseph E. Hoy
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX	16. SOCIAL SECURITY NO. XX	17. INFORMANT'S SIGNATURE OR NAME Joseph Hoy	ADDRESS Dearborn, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		5 m
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio-sclerotic heart disease DUE TO (c) 		5 1/2 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201			

19a. DATE OF OPERATION <input checked="" type="checkbox"/>	19b. MAJOR FINDINGS OF OPERATION 	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) none	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 2-1, 1949, to 4-10, 1949, that I last saw the deceased alive on 3-20, 1949, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE S. L. Durham MD	(Degree or title) MD	23b. ADDRESS Dearborn Mo.	23c. DATE SIGNED 4-11-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-12-49	24c. NAME OF CEMETERY OR CREMATORY Turner	24d. LOCATION (City, town, or county) (State) Buchanan Co. Mo.
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DATE REC'D BY LOCAL REG. April 13, 1949	REGISTRAR'S SIGNATURE E. b. Jenkins	25. FUNERAL DIRECTOR'S SIGNATURE Laughlin & Aubance	ADDRESS Dearborn Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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
Student Embalmer

Signed W. R. Vaughn

Licensed Embalmer No. 4023

P. O. Address Weston, 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, fact should be so stated above.