

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **704**

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Arkansas b. COUNTY Carroll	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Springfield)		c. CITY (If outside corporate limits, write RURAL and give OR TOWN Green Forest - Rural - Hickory)	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) DUNEAN	b. (Middle) THOMAS	c. (Last) HUGHES	4. DATE OF DEATH (Month) (Day) (Year) August 8, 1949
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5. SEX male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan 6, 1891	9. AGE (In years last birthday) 58	10. UNDER 1 YEAR 7	11. UNDER 24 HRS. 2
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Green Forest, Ark.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Dunean C. Hughes	13b. MOTHER'S MAIDEN NAME Jessie Kirby	14. NAME OF HUSBAND OR WIFE Loene Hughes
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mr. Chew Ward	ADDRESS Hempden
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 Mo
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) AdenoCarcinoma Rectum	ANTECEDENT CAUSES		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	DUE TO (b)		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death. Transfusion Reaction		180X

19a. DATE OF OPERATION 8-1-49	19b. MAJOR FINDINGS OF OPERATION Adeno Ca Rectum & Metastases to Liver	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	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) (Minute)	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 **7-26**, 19**49**, to **8-8**, 19**49**, that I last saw the deceased alive on **8-7**, 19**49**, and that death occurred at **6 A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph N. Hiles M.D.	23b. ADDRESS 1609 Cherry, Springfield, Mo.	23c. DATE SIGNED 8-9-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 8-8-49	24c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	24d. LOCATION (City, town, or county) (State) Green Forest, Ark.
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DATE REC'D BY LOCAL REG. 8-10-49	REGISTRAR'S SIGNATURE W. E. Handley	25. FUNERAL DIRECTOR'S SIGNATURE Charles Nelson	ADDRESS Berryville Ark.
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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 _____

Charles Nelson

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Charles Nelson

Signed _____
Student Embalmer

Licensed Embalmer No. *Ark - 815*

P. O. Address *Benningville, Ark*

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.