

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31864

FILED OCT 7 1949

State File No.

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8027**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Wright	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mountain Grove	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital, A		d. STREET ADDRESS (If rural, give location) R.R. #1	
3. NAME OF DECEASED (Type or Print) a. (First) Lula		b. (Middle) Ellen	
		c. (Last) Hutsell	
		4. DATE OF DEATH (Month) (Day) (Year) Sept. 16, 1949	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 28, 1886	
9. AGE (In years last birthday) 63		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Huggins, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME F.F. Scott		13b. MOTHER'S MAIDEN NAME Nancy Wilson	
14. NAME OF HUSBAND OR WIFE Rielly Hutsell			
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 Ray Hutsell, Mt. Grove, Mo.		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute hemorrhagic pancreatitis	
		INTERVAL BETWEEN ONSET AND DEATH 6 days	
		ANTECEDENT CAUSES DUE TO (b) Chronic cholecystitis	
		DUE TO (c)	
		II. OTHER SIGNIFICANT CONDITIONS Essential hypertension; arteriosclerosis; arterio-nephrosclerosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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) 12th			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR? 584X	
22. I hereby certify that I attended the deceased from Sept. 15, 1949 to Sept. 16, 1949 , that I last saw the deceased alive on Sept. 16, 1949 , and that death occurred at 12:50 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE J. R. Bradley M.D.		23b. ADDRESS Barnes Hospital	
		23c. DATE SIGNED 9/16/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-16-49	
24c. NAME OF CEMETERY OR CREMATORY Mt. Grove		24d. LOCATION (City, town, or county) (State) Mt. Grove, Mo.	
DATE REC'D BY LOCAL SEP 16 1949		REGISTRAR'S SIGNATURE J. B. Laster	
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington Blvd	

OCT 19 1949

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 Me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed George H. Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis, 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.