

FILED DEC 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36569**
Registrar's No. **79**

BIRTH NO. _____ REG. DIST. NO. **52** PRIMARY REG. DIST. NO. **3009**

1. PLACE OF DEATH a. COUNTY Cape Girardeau			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY Cape Girardeau		
b. CITY (If outside corporate limits, write RURAL and give township) Jackson Mo.		c. LENGTH OF STAY (In this place) 22 days	c. CITY (If outside corporate limits, write RURAL and give township) Jackson Mo.		d. STREET ADDRESS (If rural, give location) 302 N. 1st East - St. 1
d. FULL NAME OF HOSPITAL OR INSTITUTION Mouser Nursing Home					
3. NAME OF DECEASED (Type or Print) a. (First) Joshua b. (Middle) W c. (Last) Hasting			4. DATE OF DEATH (Month) (Day) (Year) Nov. 25-1949		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Oct. 13-1872		9. AGE (In years last birthday) 76 IF UNDER 1 YEAR: Months 10 Days 15 IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME County Welfare Cape Girardeau			
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, asthma, etc. It means the disease, injury, or complication which caused death.	18. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio Sclerosis ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 9 Mys Enchito DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 10 yrs Don't know 422
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input 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)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 2 , 1949 to Nov 25 , 1949, that I last saw the deceased alive on Nov 24 , 1949, and that death occurred at 6 1/2 m., from the causes and on the date stated above.					
23a. SIGNATURE D. L. Chapman M.D.		23b. ADDRESS Franklin Mo		23c. DATE SIGNED 11-25-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 26-1949	24c. NAME OF CEMETERY OR CREMATORY New Bethel Cemetery	24d. LOCATION (City, town, or county) (State) Cape Girardeau Co Mo		
DATE REC'D BY LOCAL REG. Nov 26 1949	REGISTRAR'S SIGNATURE A. G. Sabur	FUNERAL DIRECTOR'S SIGNATURE Deabaugh-hard Jackson Mo.			

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

16
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RECEIVED 11-28-49
Health Officer No. 4
File Number 1149-6548
Date Filed

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.

Signed R. O. Laird

Signed _____
Student Embalmer

Licensed Embalmer No. 4538

P. O. Address Jackson, Miss

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.