

FILED SEP 26 1950

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30917

State File No.

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 5635 Registrar's No. 340

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Phillipsburg RR 20yr</u>	c. LENGTH OF STAY (in this place) <u>20yr</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Phillipsburg Route 2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Phillipsburg - Rt 2</u>		d. STREET ADDRESS (If rural, give location) <u>Route 2</u> <u>0532</u>	

3. NAME OF DECEASED (Type or Print) a. (First) AUSTIN b. (Middle) LEONARD c. (Last) HUTCHISON

4. DATE OF DEATH (Month) (Day) (Year) 9-8-1950

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH 8-22-1886

9. AGE (In years last birthday) (Months) (Days) 64 0 16 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming

11. BIRTHPLACE (State or foreign country) Dallas Co Mo 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Walter Hutchison 13b. MOTHER'S MAIDEN NAME Marjorie Pummell 14. NAME OF HUSBAND OR WIFE deceased

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. _____ 17. INFORMANT'S SIGNATURE OR NAME Lee Ware Phillips ADDRESS Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Paralysis for last several yrs
DUE TO (c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bed sores severe

INTERVAL BETWEEN ONSET AND DEATH 2 days

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR _____

22. I hereby certify that I attended the deceased from 7-25, 1950, to 9-8, 1950, that I last saw the deceased alive on 9-8, 1950, and that death occurred at 10 P.m., from the causes and on the date stated above.

23a. SIGNATURE Dr. Lindsay M.D. (Degree or title) 23b. ADDRESS Conway 23c. DATE SIGNED 9-15-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 9-10-1950 24c. NAME OF CEMETERY OR CREMATORY New Hope 24d. LOCATION (City, town, or county) (State) Dallas Co Mo

DATE REC'D BY LOCAL REG. 9-16-1950 REGISTRAR'S SIGNATURE Hilda L. Hays 424 25. FUNERAL DIRECTOR'S SIGNATURE L. B. Jones ADDRESS Buffalo Mo

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

Received SEP 23 1950

Laclede County Health Unit

File No : 9-50-142

Date Filed: SEP 25 1950

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Leonard B. Jones*

Licensed Embalmer No. *2508*

P. O. Address *Buffalo 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.