

FILED NOV 28 1950

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

37632

State File No. _____
REG. DIST. NO. 382 PRIMARY REG. DIST. NO. 5655 Registrar's No. 397

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Camden</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Mt. Vernon</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Climax Springs</u> <u>0150</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Sanatorium</u>		d. STREET ADDRESS (If rural, give location) <u>RFD 1</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>H</u> c. (Last) <u>Hix</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov.</u> <u>14</u> <u>1950</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>2-2-01</u>	9. AGE (In years last birthday) <u>49</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>James M. Hix</u>		13b. MOTHER'S MAIDEN NAME <u>Phillips</u>		14. NAME OF HUSBAND OR WIFE <u>Odessa Hix</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>499-03-1422</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Ruby Ann Wilson, Mo. State San.</u> ADDRESS <u>Mt. Vernon, Mo.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary tuberculosis</u>		Pulmonary tuberculosis		<u>Abt. 5 yrs.</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
		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.			

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? _____	
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22. I hereby certify that I attended the deceased from 11-12-, 1950, to 11-14- 1950, that I last saw the deceased alive on 11-14-, 1950, and that death occurred at 9:15P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>C. G. Bussler M.D.</u>		23b. ADDRESS <u>Mo. State Sanatorium Mount Vernon, Mo.</u>		23c. DATE SIGNED <u>11-15-50</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Nov. 15, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Graves, Mo.</u>		24d. LOCATION (City, town, or county) (State) _____	
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DATE REC'D BY LOCAL REG. <u>Nov 16, 1950</u>		REGISTRAR'S SIGNATURE <u>Cecil Hendricks</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Reese Funeral Home, Warsaw, Mo.</u>		ADDRESS _____	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED NOV 18 1950

Dist. File 1150-2300

Date Filed 11-18-50

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 John F. Reese

Licensed Embalmer No. 4098

P. O. Address Warsaw

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.