

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29577

State File No. ....

FILED SEP 24 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 5134 Registrar's No. 965

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural, Washington Twp</u> c. LENGTH OF STAY (In this place) <u>1 year</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Washington</u> <u>6110</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Rt. # 3, Cook Road, St. Joseph</u>		d. STREET ADDRESS (If rural, give location) <u>R.F.D. # 4</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>THEODORE</u>	b. (Middle)	c. (Last) <u>HUTCHISON</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>9 14 1951</u>

5. SEX <u>Male</u> <u>0</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u> <u>0</u>	8. DATE OF BIRTH <u>11-27-1877</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Min.
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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 <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Buchanan Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Mitchell Hutchison</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Tom Hutchison, St. Joseph, Mo.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>3 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Droopy</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Valvular Heart lesion</u> DUE TO (c) <u>-</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>-</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		<u>4214</u>

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) m.	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 April 1<sup>st</sup> 1951, to Sept 16<sup>th</sup> 1951, that I last saw the deceased alive on Sept 16, 1951, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John B. Swails M.D.</u>	23b. ADDRESS <u>Wathona, Kansas</u>	23c. DATE SIGNED <u>9/16/51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9-16-1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Agency</u>	24d. LOCATION (City, town, or county) (State) <u>Agency, Mo.</u>
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DATE REC'D BY LOCAL REGISTRAR <u>Sept 21, 1951</u>	REGISTRAR'S SIGNATURE <u>Carl C. Carter</u>	5. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Swails</u>	ADDRESS <u>St. Joseph, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Signed.....  
Student Embalmer

Signed

Student Embalmer No.....

Licensed Embalmer No. 3986

P. O. Address

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.