

No. 300
10-48

FILED SEP 27 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30804

BIRTH NO. _____ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 5725 Registrar's No. 92

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Macon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Hudson		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Hudson	
c. LENGTH OF STAY (in this place) 4 yrs.		d. STREET ADDRESS (If rural, give location) Lakeview Rest Home	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lakeview Rest Home			

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) Henry	c. (Last) Hague	4. DATE OF DEATH (Month) (Day) (Year) Aug. 7, 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 19, 1861	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner-Ret.	10b. KIND OF BUSINESS OR INDUSTRY Coal Mining	11. BIRTHPLACE (State or foreign country) Indiana	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Richard Hague	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Mary Hague
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. E. F. McChurch	ADDRESS Des Moines, Ia.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Infection & Debilitation		INTERVAL BETWEEN ONSET AND DEATH 6 mos
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Cerebral arteriosclerosis		
	DUE TO (c) Herpes zoster		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		3 wks	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 334XC	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 **7/24/51**, 19**51**, to **8/7/51**, 19**51**, that I last saw the deceased alive on **8/6/51**, 19**51**, and that death occurred at **4:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE R. L. Durando (Degree or title)	23b. ADDRESS Macon	23c. DATE SIGNED 8/11/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/9/1951	24c. NAME OF CEMETERY OR CREMATORY West Oakwood	24d. LOCATION (City, town, or county) (State) Bevier, Mo.
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DATE REC'D BY LOCAL REG. 9-8-51	REGISTRAR'S SIGNATURE Ruth Mcneely	25. FUNERAL DIRECTOR'S SIGNATURE Albert Skinner	ADDRESS Macon, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0610
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RECEIVED
MACON COUNTY HEALTH DEPARTMENT
County File No. 9.24.51
Date Filed 9.51.150
9.24.51

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.

Student _____
Student Embalmer

Signed Thos. L. Ball

Licensed Embalmer No. 4552

P. O. Address Macon, 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.