

MAR 17 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8021

396
0

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 260

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|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Greene | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Webster | |
| b. CITY OR TOWN Springfield | c. LENGTH OF STAY (In this place) 4 hrs | c. CITY OR TOWN Seymour | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS (If rural, give location) 1120 1/2 St, 1 | |

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|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Rufus b. (Middle) F. c. (Last) HANEY | | | 4. DATE OF DEATH (Month) (Day) (Year) March 12, 1952 | | |
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|-----------------|---------------------------|---|--------------------------------------|--|---|--|--|
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH Feb. 6, 1894 | | 9. AGE (In years last birthday) 58 | IF UNDER 1 YEAR Months 1 Days 6 | IF UNDER 1 HR. Hours 1 Min. 0 |
|-----------------|---------------------------|---|--------------------------------------|--|---|--|--|

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|---|--|---|--|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | 11. BIRTHPLACE (State or foreign country) Howell Co., Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA |
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|---------------------------------------|--|--|--|--|--|
| 13a. FATHER'S NAME Henry Haney | | 13b. MOTHER'S MAIDEN NAME Shone Shirley | | 14. NAME OF HUSBAND OR WIFE Sarah Haney | |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | 16. SOCIAL SECURITY NO. WW 1 | 17. INFORMANT'S SIGNATURE OR NAME VA Hospital, Springfield, Mo. | ADDRESS |
|--|-------------------------------------|--|---------|

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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriolosclerotic and hypertensive heart disease. | | | INTERVAL BETWEEN ONSET AND DEATH |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. Generalized arteriosclerosis. | | | |

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|------------------------|----------------------------------|--|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) | 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 **March 12, 1952**, to **March 12, 1952**, and that death occurred at **7:45A** m., from the causes and on the date stated above.

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|--|--|-------------------|---|--|-------------------------------------|
| 22a. SIGNATURE R. J. Bondurant, M.D., Chief, Professional Services, | | (Degree or title) | 22b. ADDRESS VA Hospital, Springfield, Mo. | | 22c. DATE SIGNED Mar. 12, 52 |
|--|--|-------------------|---|--|-------------------------------------|

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|--|--------------------------|---|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL REMOVAL | 24b. DATE 3-12-52 | 24c. NAME OF CEMETERY OR CREMATORY Unknown | 24d. LOCATION (City, town, or county) (State) Seymour, Missouri | | |
|--|--------------------------|---|--|--|--|

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| DATE REC'D BY LOCAL REG. 3-13-52 | REGISTRAR'S SIGNATURE James R. Amos, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kelley-Ferrell-Bergman; Seymour, Missouri | | |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 3 1952

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

H. K. Kelly

Signed.....
Student Embalmer

Licensed Embalmer No. *3334*

P. O. Address *Indian Land*

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.