

STANDARD CERTIFICATE OF DEATH

State File No. **42020**
 Registrar's No. **1149-A**

FILED JAN 5 1953

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Mo. b. COUNTY Wright	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) 1149 OR TOWN MANSFIELD, Mo	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 1 MANSFIELD, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION WADK OSTEOPATHIC HOSPITAL			

3. NAME OF DECEASED (Type or Print) W T Hutson			4. DATE OF DEATH (Month) (Day) (Year) 12-22-52		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 12-26-71		9. AGE (In years last birthday) 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (City and State or Foreign, Country) Poplar Bluff, Mo.	
13a. FATHER'S NAME William Hutson			13b. MOTHER'S MAIDEN NAME Mary Ford		

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. no		17. INFORMANT'S SIGNATURE OR NAME Ray Hutson, Mtn Grove, Mo	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION			

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Circulatory failure		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) Coronary thrombosis DUE TO (c) advanced arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. hypertrophy prostate		

19a. DATE OF OPERATION 12/18/52		19b. MAJOR FINDINGS OF OPERATION hypertrophy of prostate		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) 4201	
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?	

22. I hereby certify that I attended the deceased from 12/11, 1952, to 12/22, 1952, that I last saw the deceased alive on 12/22, 1952, and that death occurred at 5:28 a.m., from the causes and on the date stated above.

23a. SIGNATURE Leland E. Wetzel		23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 12/22/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/24/52		24c. NAME OF CEMETERY OR CREMATOR Broyles Cemetery	
24d. LOCATION (City, town, or county) (State) Wright Co., Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Don H. Ferrell, Mansfield, Mo			
DATE REC'D BY LOCAL REG. 12-30-52		REGISTRAR'S SIGNATURE Edith Williamson			

(Licensed Embalmer's Statement on Reverse Side)

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 Howell Farrell

Licensed Embalmer No. 4847

P. O. Address Mansfield, 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.