

FILED JAN 19 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1279

BIRTH NO.		REG. DIST. NO. 142		PRIMARY REG. DIST. NO. 5556		Registrar's No.	
1. PLACE OF DEATH a. COUNTY <u>Shannon Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Carter</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Mountain View</u>		c. LENGTH OF STAY (If this place) <u>8 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Fremont</u>		<u>0150</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial</u>				d. STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u>		b. (Middle) <u>E.</u>		c. (Last) <u>Hoagland</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 4 1953</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 15 1879</u>	
9. AGE (In years last birthday) <u>73</u>		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Hours		12. IF UNDER 24 HRS. Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Dent Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Samuel Hoagland</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Weeks</u>		14. NAME OF HUSBAND OR WIFE <u>Alice Hoagland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Alice Hoagland Fremont Mo</u>			
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) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) <u>4201</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hour</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pneumonia, Virus</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 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 <u>Dec 26 1952</u> to <u>Jan 4 1953</u> , that I last saw the deceased alive on <u>Jan 4 1953</u> , and that death occurred at <u>5 P m.</u> from the causes and on the date stated above.							
23a. SIGNATURE (Degrees or title) <u>Thomas R. Hayes Md</u>				23b. ADDRESS <u>Mt View Mo</u>		23c. DATE SIGNED <u>Jan 8 53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 6</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hamnider Family</u>		24d. LOCATION (City, town, or county) (State) <u>Carter Co Mo</u>	
DATE REC'D BY LOCAL REG. <u>1-5-53</u>		REGISTRAR'S SIGNATURE <u>Louise Mitchell/26-1</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Seaton Pewitt Van Buren Mo</u>			

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

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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 *Seaton Pruitt*

Licensed Embalmer No. *2287*

P. O. Address *Van Buren m*

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.