

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **27465**

No. 300
10-48

FILED JUL 21 1953

BIRTH NO. _____ REG. DIST. NO. 348 PRIMARY REG. DIST. NO. 4510 Registrar's No. 4

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Osgood</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Osgood</u>	
c. LENGTH OF STAY (If this place) <u>Life</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>FRANK</u> c. (Last) <u>HATCHER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7-9-53</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>11-17-1879</u>	9. AGE (In years last birthday) <u>73</u>	10. MONTHS <u>0</u>
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 _____		11. BIRTHPLACE (State or foreign country) <u>Lundy Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>Isaac Hatcher</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Doolin</u>		14. NAME OF HUSBAND OR WIFE <u>Annie Hatcher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Ray Hatcher</u> ADDRESS <u>Osgood Mo</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION <u>Carcinoma Prostate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		DUE TO (b) _____			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		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) <u>177X</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from 1-1-, 1950, to 7-9-, 1953, that I last saw the deceased alive on 7-6-, 1953, and that death occurred at 2:50 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>W.C. Weston M.D.</u> (Degree or title)		23b. ADDRESS <u>Galt Mo</u>		23c. DATE SIGNED <u>7-11-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-12-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Camp Ground</u>	
24d. LOCATION (City, town, or county) (State) <u>Osgood Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>PK Payne</u> ADDRESS <u>Galt Mo</u>			
DATE REC'D BY LOCAL REG. <u>JUL 20 1953</u>		REGISTRAR'S SIGNATURE <u>Edw. A. Bridges</u>			

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

Handwritten scribbles

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 P. K. Payne Jr.

Licensed Embalmer No. 3400

P. O. Address Galt

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.

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