

8114-54 STANDARD CERTIFICATE OF DEATH

BIRTH NO. FILED MAR 1 1954 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 202-B

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHNS HOSP.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD CABOOL	
		d. STREET ADDRESS (If rural, give location) 1070	
3. NAME OF DECEASED (Type or Print) a. (First) ROBERT		b. (Middle)	
		c. (Last) HUGHES JR.	
4. DATE OF DEATH (Month) (Day) (Year) FEB 18 1954			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) INFANT	8. DATE OF BIRTH FEB 17, 1954
9. AGE (In years last birthday) -- --		10. UNDER 1 YEAR (Months) --	11. UNDER 1 MRS. (Hours) (Mins.) 23 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (City and State or Foreign Country) SPRINGFIELD, MO	
		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME ROBERT HUGHES		13b. MOTHER'S MAIDEN NAME JO ANN MATHERLY	
14. NAME OF HUSBAND OR WIFE --			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT'S SIGNATURE OR NAME Jo Ann Hughes		ADDRESS CABOOL 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) CONGENITAL ATELECTASIS, BILATERAL	
		INTERVAL BETWEEN ONSET AND DEATH 233 1/2 hrs	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CLEFT PALATE, SEVERE 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 7620	
20. AUTOPSY? YES <input checked="" 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 FEB 17, 1954 , to FEB 18, 1954 , that I last saw the deceased alive on FEB 18, 1954 , and that death occurred at 11:40 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) John P. Ferguson M.D.		23b. ADDRESS Springfield, Mo.	
23c. DATE SIGNED 2-18-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 2-20-54	
24c. NAME OF CEMETERY OR CREMATOR CABOOL CEMET.		24d. LOCATION (City, town, or county) (State) CABOOL, MO.	
DATE REC'D BY LOCAL REG. 2-23-54		REGISTRAR'S SIGNATURE E. Williams	
25. FUNERAL DIRECTOR'S SIGNATURE Elliott Nentry		ADDRESS Cabool, Mo.	

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

No embalming
Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.