

FILED APR 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12694

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>110</u>			
1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Pike</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u>		c. LENGTH OF STAY (in this place) <u>17 days</u>		c. CITY OR TOWN <u>New Canton</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Elizabeth</u>				e. STREET ADDRESS (If rural, give location) <u>8128</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>George S.</u> b. (Middle) _____ c. (Last) <u>Hyde</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 19, 1954</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>December 24, 1881</u>		9. AGE (In years last birthday) <u>72</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Apiary</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (City and State or foreign Country) <u>New Canton Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13a. FATHER'S NAME <u>William H. Hyde</u>			13b. MOTHER'S MAIDEN NAME <u>Jenny O'Neil</u>		14. NAME OF HUSBAND <u>Elizabeth Allison Hyde</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u> (If yes, give war or dates of service) <u>XX</u>		16. SOCIAL SECURITY NO. <u>XX</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Clara Hyde New Canton Illinois</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial failure</u> ANTECEDENT CAUSES <u>Debile myocarditis</u> DUE TO (b) _____ <u>Coronary Sclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>5 yrs.</u> <u>2 yrs.</u>		
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>1561</u>					
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>Jan 22</u> , 19 <u>54</u> to <u>April</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>April 19</u> , 19 <u>54</u> , and that death occurred at <u>09:15 AM</u> on the causes and on the date stated above.									
23a. SIGNATURE (Type or Print) <u>Tom Russell M.D.</u>				23b. ADDRESS <u>Hull</u>		23c. DATE SIGNED <u>4/19/54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4/21/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn</u>		24d. LOCATION (City, town, or county) (State) <u>Barry Illinois</u>			
DATE REC'D BY LOCAL REG. <u>4-19-54</u>		REGISTRAR'S SIGNATURE <u>Dr. C. M. Luedtke M.D. F.A.C.P.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fred J. Hubragel</u>		ADDRESS <u>Barry, Illinois</u>			

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

APR 28 1954
RECEIVED
MARIGN CO. HEALTH DEPT.
DATE FILED APR 28 1954

SEP 22 1954

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 This body was not embalmed....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *W. Crawford Smith*

Licensed Embalmer No... *J. S. 1*

P. O. Address *Wassell*
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.