

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15789**  
Registrar's No. **87**

FILED MAY 26 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **157** PRIMARY REG. DIST. NO. **3028**

1. PLACE OF DEATH a. COUNTY <b>Jasper</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jasper</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Carthage</b>		c. CITY OR TOWN <b>Carthage</b>	
c. LENGTH OF STAY (in this place) <b>1 day</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mc Cune Brooks Hosp.</b>		STREET ADDRESS (If rural, give location) <b>Rt. #4</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>William</b> b. (Middle) <b>Frank</b> c. (Last) <b>Haggard</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>5-20-1955</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>3-27-1904</b>	9. AGE (In years last birthday) <b>51</b>	IF UNDER 1 YEAR Months Days IF UNDER 48 Hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Acid line Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Atlas Powder</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Peoria, Ill</b>	
13a. FATHER'S NAME <b>Andrew D. Haggard</b>		13b. MOTHER'S MAIDEN NAME <b>Unk</b>		14. NAME OF HUSBAND OR WIFE <b>Madge Simmons</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>500-09-2043</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. W.F. Haggard Carthage, Mo.</b>	

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Subarachnoid hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Essential hypertension</b>				<b>33 years</b>	
		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)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		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 **9/7, 1954**, to **5/19, 1955**, that I last saw the deceased alive on **5/19, 1955**, and that death occurred at **12:15 A.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Charles F. Schell M. D.</b>		23b. ADDRESS <b>201 W. Third Carthage, Missouri</b>		23c. DATE SIGNED <b>5/20/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>5-23-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Park Cemetery</b>	
				24d. LOCATION (City, town, or county) (State) <b>Carthage, Mo.</b>	

DATE REC'D BY LOCAL REG. <b>5-21-55</b>		REGISTRAR'S SIGNATURE <b>W. Clinton</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ulmer Funeral Home Carthage, Mo.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Date Filed

MAY 25 1955

1955

JUN

FEB 21 1956

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.....  
Signature of Student Embalmer

Signed *William B. Conner*

Licensed Embalmer No. *48*

P. O. Address *Parth...*

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.