

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30009

STATE FILE NUMBER

FILED OCT 2 1956

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 255

Health,  
Welfare  
Public  
Service

300-  
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>CALLAWAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CALLAWAY</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FULTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>FULTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STATE HOSPITAL # 1</u>		Length of stay in lb <u>4 Days</u>		d. STREET ADDRESS (If outside, give location) <u>300 State Street</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RALE</u> Middle <u></u> Last <u>HANKS</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 21, 1895</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHYSICIAN I PSYCHIATRY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MEDICAL PROFESSION</u>		11. BIRTHPLACE (City and state or country) <u>Brashear Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr. James Hanks</u>				14. MOTHER'S MAIDEN NAME <u>Estella Hopkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>W.W. 1 500-34-3411</u>		17. INFORMANT <u>STATE HOSPITAL # 1, FULTON, MISSOURI</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 HOURS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. <u>STATE HOSPITAL</u> Attended the deceased from <u>1945</u> to <u>1956</u> and last saw her <u>her</u> alive on <u>9-21-56</u> Death occurred at <u>3:20 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>H. S. Knotts, M.D.</u>		22b. ADDRESS <u>FULTON, MO</u>		22c. DATE SIGNED <u>(9/24/1956)</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Sept. 27/56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gallaway Mem. Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Fulton Mo.</u>	
24. FUNERAL DIRECTOR <u>Maupin Home</u>		ADDRESS <u>Fulton Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 29-1956</u>		26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>	

(Licensed Embalmer's Statement on Reverse Side)

101 5  
1951

1951 8 1 934

1951 8 1 934

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ..... Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *J. J. Ross*.....  
Licensed Embalmer No. *25*.....

P. O. Address *.....*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
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.