

with welfare public service  
 000 -56  
 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 Doctor, Coroner, or other person authorized by law to certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

41145

STATE FILE NUMBER

FILED DEC 17 1956

71702-56 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 823-B

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Oklahoma</b> b. COUNTY <b>Delaware Co</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Maysville, Arkansas</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Hospital</b>		d. STREET ADDRESS <b>Route #2</b>	
Length of stay in 1b <b>20 minutes</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Outside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>GOLDEN</b> Middle <b>WILLARD</b> Last <b>HYER</b>			4. DATE OF DEATH Month <b>September</b> Day <b>9</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 9, 1956</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <b>3</b> Days <b>8</b> IF UNDER 24 HRS.: Hours <b>3</b> Min.	
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 country) <b>McDonald County Hospital Noel, Missouri</b>	
13. FATHER'S NAME <b>John Thomas Hyer</b>			14. MOTHER'S MAIDEN NAME <b>Zelma Elizabeth Flaming</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, no. or unknown) (If yrs, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Address</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Foetal atelectasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day<sup>3</sup> hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Premature birth</b> DUE TO (c)		
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 <b>4:20</b> Month <b>p</b> Day <b>9</b> Year <b>1956</b>		
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 <b>Springfield, Missouri</b> COUNTY <b>Delaware</b> STATE <b>Oklahoma</b>

21. I attended the deceased from **Sept 9 1956** to **Sept 9 1956** and last saw her/him alive on **Sept 9, 1956**  
 Death occurred at **4:20 p** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Dorval A. Thompson MD</b> (Degree or title)	22b. ADDRESS <b>Springfield, Missouri</b>	22c. DATE SIGNED <b>12/12/56</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>removal</b>	<b>Sept 11, 1956</b>	<b>Mt. Herman Cemetery</b>	<b>Delaware Co., Oklahoma</b>
24. FUNERAL DIRECTOR <b>A. M. Humphrey</b> ADDRESS <b>Noel Mo. 12-13-56</b>	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <b>Edith Williams</b>	

(Licensed Embalmer's Statement on Reverse Side)

**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 Not Embalmed, Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed F. M. Humphrey

Licensed Embalmer No. 47

P. O. Address Noel

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