

Health, Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All 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

FILED FEB 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4160

STATE FILE NUMBER

Registration District No. 93 Primary Registration District No. 5346 Registrar's No. 57-17

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>So. Morgan twp</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Dadeville</u> <u>0290</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home 3mi East</u>		d. STREET ADDRESS <u>3mi E Dadeville Mo.</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Alexander</u> Last <u>VanHooser</u>		4. DATE OF DEATH <u>Feb 13 1957</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (City and state or country) <u>Dade Co Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	
13. FATHER'S NAME <u>Jas. W VanHooser</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Frank VanHooser</u>		Address <u>Dadeville Mo rt</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>Arterio Sclerosis</u> DUE TO (b) <u>Senility</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause: (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Not Known</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 _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
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. I attended the deceased from <u>2-12-</u> to <u>2-13-57</u> and last saw ^{see} him alive on <u>2-12-57</u> Death occurred at <u>9:30pm</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R.D. Combs, M.D.</u> (Dee or title)		22b. ADDRESS <u>Lackwood Mo</u>	22c. DATE SIGNED <u>2-15-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb 16 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenfield Mo</u>	23d. LOCATION (City, town, or county) (State) <u>Greenfield Mo.</u>
24. FUNERAL DIRECTOR <u>W.R. Allison</u> ADDRESS <u>Greenfield Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-16-1957</u>	26. REGISTRAR'S SIGNATURE <u>J.C. Canada</u>

(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, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *W. R. Allison*.....

Licensed Embalmer No. *44*

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

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.