

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7826

FILED MAR 28 1957

Registration District No. 43 Primary Registration District No. 4057 STATE FILE NUMBER 246 Registrar's No. 246

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Butler</u>	a. STATE <u>Mo</u> b. COUNTY <u>Butler</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Oulin</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Oulin</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>at Residence</u>	Length of stay in 1b <u>17 years</u>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <u>Sarah</u>	Middle <u>Ann</u>	Last <u>Hargiss</u>	Month <u>March</u>	Day <u>13</u>	Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>1976-11-27</u>	9. AGE (In years last birthday) <u>80-3-14</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeping at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Paducah Ky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Able Huffman</u>		14. MOTHER'S MAIDEN NAME <u>Carolyn Huffman</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>Jess Hargiss-Oulin, Mo</u> Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the left lung & metastases</u>		?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (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 <u>1</u> Month <u>11</u> Day <u>27</u> a. m. <u>14</u> 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		STATE

21. I attended the deceased from 3/11/57 to _____ and last saw her ^{him} alive on 3/11/57
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Wallace A Belsky, M.D.</u>	22b. ADDRESS <u>0 Campbell, Mo.</u>	22c. DATE SIGNED <u>3/15/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-16-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Malden Park Memorial</u>	23d. LOCATION (City, town, or county) (State) <u>N of Malden Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas C. Knight</u>		25. DATE RECD. BY LOCAL REG. <u>3/23/57</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

(Licensed Embalmer's Statement on Reverse Side)

300
 0-56
 health, Welfare Public Service
 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

19-0

RECEIVED

MAR 25 1957

BUTLER CO. HEALTH CENTER

FILE No. _____

MAR 18 1957

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 *Thomas C. Knight*

Licensed Embalmer No. *218*

P. O. Address *Malden*

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.