Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 24 1957

34639

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 160

1. PLACE OF DEATH
a. COUNTY Vernon
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Washington Township — Inside Limits Yes ☐ No ☑
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) State Hospital #3. — Length of stay in 1b 13yrs 9m. 16d

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Greene
c. CITY OR TOWN Springfield 039 — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 738 West Olive — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Belfy Middle — Last Huckaby

4. DATE OF DEATH Month 9 Day 11 Year 1957

5. SEX male
6. COLOR OR RACE white — MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 9. 8. 1890
9. AGE (In years last birthday) 67 — IF UNDER 1 YEAR Months — Days 3 — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic
10b. KIND OF BUSINESS OR INDUSTRY unknown
11. BIRTHPLACE (City and state or country) Lebanon, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Thomas Huckaby
13b. MOTHER'S MAIDEN NAME Mandy J. Jones
14. NAME OF HUSBAND OR WIFE unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. unknown
17. INFORMANT State Hospital #3 Address Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH years
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) Luetic Meningoencephalitis. 025X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) none
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year none
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 12/31/56, to 9/11/57 and last saw her/him alive on 9/11/57
Death occurred at 7:15 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George Esker M.D.
22b. ADDRESS State Hospital #3 Nevada
22c. DATE SIGNED 9/11/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 1957 Sept. 11
23c. NAME OF CEMETERY OR CREMATORY Local
23d. LOCATION (City, town, or county) (State) Springfield, Missouri

24. FUNERAL DIRECTOR ADDRESS Ferry Funeral Home Nevada, Mo.
25. DATE RECD. BY LOCAL REG. 9-18-1957
26. REGISTRAR'S SIGNATURE Anna E. Ferry

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

2

10

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 L. Douglas Terry

Licensed Embalmer No. 4960

P. O. Address Nevada, Mo.

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.