

pt. Health,  
r., & Welfare  
S. Public  
alth Service

FILED OCT 17 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

388882

STATE FILE NUMBER

Registration District No. 238 Primary Registration District No. 6148 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY <b>Stoddard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>7</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bell City, Rural</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>Bell City, R, 10</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Residence</b> Length of stay in 1b <b>27 yr,</b>		d. STREET ADDRESS (If outside, give location) <b>Rural R. 1.</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Joe</b> First <b>Hughes</b> Middle <b>Hughes</b> Last			4. DATE OF DEATH <b>October 8, 1957</b> Month <b>October</b> Day <b>8</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1898</b>	9. AGE (In years last birthday) <b>58</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>5</b> Days <b>12</b> Hour <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	11. BIRTHPLACE (City and state or country) <b>Parire, Mississippi</b>	12. CITIZEN OF WHAT COUNTRY? <b>U, S, A,</b>	
13. FATHER'S NAME <b>Joe Hughes</b>			14. MOTHER'S MAIDEN NAME <b>Allie Hughes</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>xxxx No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Pearl Hughes Bell City, R, L</b> Address		

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>viral pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>492x</b> DUE TO (c) <b>2</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac hypertension, + Ventricular fibrillation</b>		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 a. m. <b></b> p. m. <b></b> Hour <b></b> Month, Day, Year <b></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 COUNTY STATE
21. I attended the deceased from <b>9-27-57</b> to <b>10-9-57</b> and last saw her/him alive on <b>10-8-57</b> . Death occurred at <b>10:00</b> <b>p</b> - m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <b>James O. Cameron D.O.</b>	22b. ADDRESS <b>Bloomfield - 720</b>	22c. DATE SIGNED <b>10-9-57</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b></b>	23b. DATE <b>10-13-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Carpenter</b>	23d. LOCATION (City, town, or county) (State) <b>N.W. Sikeston, MO</b>
24. FUNERAL DIRECTOR ADDRESS <b>Fred Smith 1212 Maud St</b>		25. DATE RECD. BY LOCAL REG. <b>10-11-57</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. George L. Baker</b>

(Licensed Embalmer's Statement on Reverse Side)

S. 300  
ev. 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

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...specific manner required by 193.140 MO RS 1949.

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 *Fred J. Smith*  
Licensed Embalmer No. *440*

P. O. Address *Likeston*

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.