

FILED DEC 12 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39387

XC-2102485  
REG.# 15496

STATE FILE NUMBER

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 47

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ARKANSAS</b> b. COUNTY <b>RANDOLPH</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>MAYNARD</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>VETERANS ADM. HOSPITAL</b>		Length of stay in lb <b>6 Days</b>	d. STREET ADDRESS <b>ROUTE ONE</b>		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>MOSES</b> Last <b>HURLEY</b>			4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>3</b> Year <b>1957</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-28-95</b>	9. AGE (In years last birthday) <b>62</b>	10. UNDER 1 YEAR Months Days Hours Min.
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>AGRICULTURE</b>	11. BIRTHPLACE (City and state or country) <b>PORTAGEVILLE, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>RICHARD HURLEY</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>CLARA BELL HURLEY (Deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</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>BRONCHOPNEUMONIA, RIGHT AND LEFT LOWER LOBES, ACUTE, SEVERE.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>16 Days</b>
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. DUE TO (b) <b>Jew.</b> DUE TO (c) <b>491X</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1. Malnutrition, severe. 2. Arteriosclerosis, generalized</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. Month, Day, Year p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> attended the deceased from <b>Nov. 27, 1957</b> to <b>Dec. 3, 1957</b> Death occurred at <b>8:05 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Robert S. Cohen</b> <b>ROBERT S. COHEN, M.D., Chief, Med.Svc.</b>			22b. ADDRESS <b>VA HOSPITAL, POPLAR BLUFF, MO.</b>		22c. DATE SIGNED <b>12/4/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-5-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Doniphan Cemetery</b>		23d. LOCATION (City, town, or county) <b>Doniphan, Missouri</b> (State)	
24. FUNERAL DIRECTOR <b>M. C. McNeill</b> ADDRESS <b>Pocahontas, Ark.</b>		25. DATE REC'D. BY LOCAL REG. <b>12/7/57</b>	26. REGISTRAR'S SIGNATURE <b>B. B. Muehler</b>		

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STATE OF OHIO  
DEPARTMENT OF HEALTH

RECEIVED

DEC 9 1957  
BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

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 *M. E. Mc Gill*

Licensed Embalmer No. *680 Ark.*

P. O. Address *Parabank, W. Va.*

Notes: 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.