

Health, Welfare, Public Service

FILED JAN 20 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

895

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 53

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>DADE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>GREENFIELD</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>BAPTIST HOSPITAL</u>		Length of stay in 1b <u>2 hr</u>	d. STREET ADDRESS (If outside, give location) <u>Rt. #2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HATTIE</u> Middle <u>MYRTLE</u> Last <u>DeHART</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>13,</u> Year <u>1958</u>	
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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>Dec. 27, 1894</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Dade County, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Finis Duncan</u>	13b. MOTHER'S MAIDEN NAME <u>Janie Colclasure</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
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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>Mrs. Alfa Killingsworth, Greenfield</u> Address
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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>Infarction, massive, small bowel</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Massive mesenteric venous thrombosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>48 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>5702</u>		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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT <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 <u>Greenfield</u>	COUNTY <u>Dade</u>	STATE <u>Missouri</u>
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21. I attended the deceased from <u>1-13-58</u> , to <u>1-13-58</u> and last saw her/him alive on <u>1-13-58</u> Death occurred at <u>1:40 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Melton W. Wood M.D.</u> (Degree or title)	22b. ADDRESS <u>1211 Po Kenstone Springfield Mo.</u>	22c. DATE SIGNED <u>1/13/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-15-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Vaughn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Dade County, Missouri</u>
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24. FUNERAL DIRECTOR <u>CANADA FUNERAL HOME</u>	ADDRESS <u>Greenfield</u>	25. DATE RECD. BY LOCAL REG. <u>1-14-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>
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(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.

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JAN 29 1958

APR 21 1959

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 *Frederick T. Swadlow*

Licensed Embalmer No. *1575*

P. O. Address *Springfield*

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.