

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH58-010615  
State File No. ....

FILED APR 8 1958

BIRTH NO. _____		REG. DIST. NO. <u>184</u>		PRIMARY REG. DIST. NO. <u>3038</u>		Registrar's No. <u>45</u>	
1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Linn</u> c. CITY OR TOWN <u>0581</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Brookfield</u> )		c. LENGTH OF STAY (in this place) <u>5 da.</u>		c. CITY OR TOWN <u>Marceline</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>McLarney Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>124 E. Lake</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Gertrude</u>		b. (Middle) _____		c. (Last) <u>Hosford</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3/29/58</u>	
5. SEX <u>F /</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M /</u>		8. DATE OF BIRTH <u>9/17/1890</u>	
9. AGE (In years last birthday) <u>67</u>		IF UNDER 1 YEAR Months <u>6</u>		IF UNDER 1 YEAR Days <u>12</u>		IF UNDER 1 HRS. Hours <u></u> Min. <u></u>	
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 _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Miami, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Joseph Hightower</u>		13b. MOTHER'S MAIDEN NAME <u>Julia (Unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>Charles</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'S SIGNATURE OR NAME <u>Bertha Hightower</u>		ADDRESS <u>Marceline, Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Memor.</u>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Glomerular nephritis</u> DUE TO (c) <u>Renovascular disease with diabetes mellitus.</u> Conditions contributing to the death but not related to the disease or condition causing death. <u>Gangrene of rt. leg.</u> <u>260X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 day.</u> <u>1 yr.</u> <u>10 yrs</u>	
19a. DATE OF OPERATION <u>3/23/58</u>		19b. MAJOR FINDINGS OF OPERATION <u>Amputation of rt. leg at mid thigh.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>2</u>			
22. I hereby certify that I attended the deceased from <u>3/13</u> , 19 <u>56</u> , to <u>3/29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/29</u> , 19 <u>58</u> , and that death occurred at <u>5:32</u> m. from the causes and on the date stated above.							
23a. SIGNATURE <u>R. B. Johnson M.D.</u> (Degree or title) <u>0</u>				23b. ADDRESS <u>Brookfield Mo</u>		23c. DATE SIGNED <u>3/31/58</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24b. DATE <u>3/31/58</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		24d. LOCATION (City, town, or county) (State) <u>Marceline, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>3-31-58</u>		REGISTRAR'S SIGNATURE <u>Katharine Johnson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>James M Laughlin Marceline, Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *James B. Mc Clelland*.....

Licensed Embalmer No. *4230*.....

P. O. Address *Brookfield, M*.....

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.