

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017477

STATE FILE NUMBER

FILED JUN 10 1958 Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 131

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Fulton 0143</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Callaway Hosp</u>		Length of stay in lb <u>3 Wks</u>	d. STREET ADDRESS (If outside, give location) <u>826 Jefferson</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Thomas</u> Last <u>Sutton</u>			4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>58</u>
5. SEX <u>Male</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>JAN 27-1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) # <u>State Employee Hosp</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (In years last birthday) <u>87</u> IF UNDER 1 YEAR Months <u>4</u> Days <u>20</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>Kensett ARK.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>Julia Sutton</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>5-00-34-7507</u>	17. INFORMANT <u>C.W. Sutton</u> Address <u>6912 Woodrow St Louis-20-MO</u>
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>① leukemia</u> DUE TO (b) <u>② Advanced Cardiovascular renal arteriosclerosis</u> DUE TO (c) <u>③ sinus progressive and severe</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>years</u> <u>6 mths</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>gangrene & toes right foot secondary to 2 above</u>			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 Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
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	COUNTY STATE
21. I attended the deceased from <u>9 April 1956</u> to <u>7 June 58</u> and last saw him alive on <u>6 June 58</u> Death occurred at <u>6:30</u> A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>S. R. Mohr MD</u> (Degree or title)		22b. ADDRESS <u>Fulton Mo</u>	22c. DATE SIGNED <u>7 June 58</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6-10-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sidon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sidon ARK.</u>
24. FUNERAL DIRECTOR <u>Claypool Fun. Home New Bloomfield</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>June 7-1958</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 16. No symptoms will be stated. All diseases in Part I must be causally related.

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 *Le Roy Claypool*

Licensed Embalmer No. *4412*

P. O. Address *New Blenheim*

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.