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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-017966

STATE FILE NUMBER

FILED MAY 20 1958

Registration District No. 140

Primary Registration District No. 3024

Registrar's No. 36

300  
1-57

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Howard</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Fayette</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Fayette</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lee Hospital</b>		Length of stay in lb <b>70 days</b>	d. STREET ADDRESS (If outside, give location) <b>206 W. Morrison</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Asa</b> Last <b>Hancock</b>			4. DATE OF DEATH Month <b>May</b> Day <b>1</b> , Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 22, 1879</b>		9. AGE (In years last birthday) <b>79</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Police Judge</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City of Fayette</b>	11. BIRTHPLACE (City and state or country) <b>Howard Co. Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>William Williams Hancock</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Brashear</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs Earl Buckner Fayette, 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>Cerebral Thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <b>Chronic Arteriosclerosis</b>					<b>2 Yrs</b>
DUE TO (c) <b>Chronic Prostatic Obstruction</b>					<b>One yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 _____, to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>W. Bloom M.D.</b>			22b. ADDRESS <b>Fayette Mo.</b>		22c. DATE SIGNED <b>5/5/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/4/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fayette City Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Fayette, Missouri</b>
24. FUNERAL DIRECTOR <b>Ralph A. Carr</b>		ADDRESS <b>Fayette, Missouri</b>		25. DATE RECD BY LOCAL REG. <b>5/5/58</b>	26. REGISTRAR'S SIGNATURE <b>Mary K. Shell</b>

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, ~~only~~....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Ralph A. Carr*.....

Licensed Embalmer No. *3340*.....

P. O. Address *Jayette, Mo*.....

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.