. Health,
& Welfare
. Public
h Service

S. 300
. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-033796
STATE FILE NUMBER

FILED OCT 7 1958 Registration District No. 282 Primary Registration District No. 5980 Registrar's No. 106

1. PLACE OF DEATH
a. COUNTY Polk
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural-Wishart — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Died in the Home — Length of stay in 1b 61 yr.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Polk
c. CITY OR TOWN Rural-Wishart — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First: Oral Middle: M. Last: Hughes
4. DATE OF DEATH Month Day Year: Sept. 22, 1958
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 13, 1878
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Warner Hughes
13b. MOTHER'S MAIDEN NAME: Emilee Smith
14. NAME OF HUSBAND OR WIFE: Lillie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Mrs. Irl Ruckman Address: Bolivar, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion,
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerotic Heart Disease,
DUE TO (c) 4200

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 ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Aug. 1956, to Sept. 10-58 and last saw him alive on Sept. 10-58
Death occurred at 11:20 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L D Smith, M.D. (Degree or title)
22b. ADDRESS Bolivar Mo.
22c. DATE SIGNED Sept. 29-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Sept. 24, 58
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
23d. LOCATION (City, town, or county) (State): Bolivar, Mo.

24. FUNERAL DIRECTOR ADDRESS: Pitts Funeral Home — Bolivar, Mo.
25. DATE RECD. BY LOCAL REG.: Sept 30, 1958
26. REGISTRAR'S SIGNATURE: Ralph Gordon per Jewell Gordon

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 Sidney J. Pitts

Licensed Embalmer No. 4939

P. O. Address Bolivar, 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.