

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035152

STATE FILE NUMBER

FILED OCT 14 1958 Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 113

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		c. CITY OR TOWN <b>Marshall</b> c. <b>972</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Fitzgibbon Hosp.</b>		d. STREET ADDRESS <b>605 E Gordon</b> (If outside, give location)	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>FREDRICK</b> Last <b>ENGLISH</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>7</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 type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1874</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Farming (unknown)</b>		11. BIRTHPLACE (City and state or country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>			
14. MOTHER'S MAIDEN NAME <b>Unknown</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 <b>Mrs. Florene Hunter 605 E Gordon</b> Address <b>Marshall</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 Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 am</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral Arterio Sclerosis</b>	<b>102 am</b>
	DUE TO (c) <b>Hypertensive Cordis Vasculi di</b>	<b>107 am</b>

PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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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.) <b>443X</b>	
20c. TIME OF INJURY a. m. _____ p. m. _____	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>443X</b>	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <b>Marshall, Missouri</b>	COUNTY _____ STATE _____

21. I attended the deceased from **May 1956** to **Oct 6, 1958** and last saw <sup>him</sup> alive on **Oct 6, 1958**  
Death occurred at **6:10** a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Howie Bohne MD</i> (Degree or title)	22b. ADDRESS <b>Marshall, Missouri</b>	22c. DATE SIGNED <b>10-7-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-7-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Orient Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Harrisonville, Missouri</b>
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24. FUNERAL DIRECTOR <b>Sweeney-Rose Funeral Home</b> ADDRESS <b>Marshall</b>	25. DATE RECD. BY LOCAL REG. <b>10-7-58</b>	26. REGISTRAR'S SIGNATURE <i>Carl G. Reed</i>
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(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300 1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.....  
*Jack W. Reese*

Licensed Embalmer No. *46*

P. O. Address *Marshall*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.