

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037860

STATE FILE NUMBER

NOV 10 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10310

S. 300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Elsberry</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>31</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM D. HINES</u>			4. DATE OF DEATH Month Day Year <u>OCTOBER 27, 1958</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18-1926</u>
9. AGE (In years last birthday) <u>32</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical work</u>	11. BIRTHPLACE (City and state or country) <u>Lincoln Co., Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Thomas Hines</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Belle Meyer</u>
14. NAME OF HUSBAND OR WIFE <u>none</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>495-34-1581</u>
17. INFORMANT <u>Miller Funeral Home, Elsberry, Mo.</u>		Address	
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>CIRCULATORY COLLAPSE, POST-OPERATIVE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>INTERVENTRICULAR SEPTAL DEFECT</u>			<u>32 YEARS</u>
DUE TO (c) <u>CONGENITAL HEART DISEASE</u> <u>754.2</u>			
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 checked="" type="checkbox"/> NO <input 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>OCT. 20, 1958</u> to <u>OCT. 27, 1958</u> and last saw ^{her} _{him} alive on <u>OCT. 27, 1958</u> Death occurred at <u>12:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>C. P. Mellish, M. D.</u> (Degree or title)		22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>10/27/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Oct. 27, 58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Star Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lincoln Co., Mo.</u>
24. FUNERAL DIRECTOR <u>Miller F. Home-Elsberry, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 28 58</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
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.

MAY 22 1959

NEW YORK STATE

DEPARTMENT OF HEALTH

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
ALBANY, NEW YORK

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 Howey Kable
Licensed Embalmer No. 4596
P. O. Address Floussant

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.