

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043930
STATE FILE NUMBER

FILED DEC 22 1958

Registration District No. 142 Primary Registration District No. 5886 Registrar's No. 65-

300
1-57

1. PLACE OF DEATH a. COUNTY Howell		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Fulton	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mtn. View,		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN near Salem <u>8030</u> <u>8</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis		Length of stay in lb 3 days	d. STREET ADDRESS (If outside, give location) Star Route
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First HELEN Middle MARY Last HALLANE	4. DATE OF DEATH Month Dec. Day 6, Year 1958
--	--

5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 22, 1886	9. AGE (In years last birthday) 72	FUNDER 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) Cashier (retired)	10b. KIND OF BUSINESS OR INDUSTRY restaurant	11. BIRTHPLACE (City and state or country) Chicago, Ill.	12. CITIZEN OF WHAT COUNTRY? USA
---	--	--	--

13a. FATHER'S NAME Charles Goldthwaite	13b. MOTHER'S MAIDEN NAME Ella Pearsons	14. NAME OF HUSBAND OR WIFE Carl E. Hallane
--	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 318-10-6548A	17. INFORMANT Carl E. Hallane, Salem, Ark.
--	--	--

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>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral arteriosclerosis</u>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X		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>12/1/58</u> to <u>12/6/58</u> and last saw her alive on <u>12/6/58</u> Death occurred at <u>7:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>M. L. Fowler</u> (Degree or title) <u>MD</u>	22b. ADDRESS West Plains, Mo.	22c. DATE SIGNED 12-12-58
---	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Dec. 9, 1958	23c. NAME OF CEMETERY OR CREMATORY Howell Valley Cem.	23d. LOCATION (City, town, or county) (State) Howell Co., Missouri
--	----------------------------------	---	--

24. FUNERAL DIRECTOR <u>Hal Thourmond</u>	ADDRESS CARTER FUNERAL HOME WEST PLAINS, MO.	25. DATE RECD. BY LOCAL REG. 12-19-58	26. REGISTRAR'S SIGNATURE <u>Louise Mitchell</u>
--	--	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Vertical text on the left margin: 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, ~~only~~....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Hal Saenger*.....

Licensed Embalmer No. *3408*.....
CARTER FUNERAL HOME
WEST PLAINS, MO.
P. O. Address

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.