

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044747

STATE FILE NUMBER

FILED JAN 5 1958

Registration District No. 171 Primary Registration District No. 5639 Registrar's No. 60

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington Twp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Near Odessa 6540</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b <b>20 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>3 Miles SE of Odessa</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Dora</b> Middle <b>Pearl</b> Last <b>Hyatt</b>			4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 27, 1892</b>	9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months <b>66</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Lafayette Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME <b>Robert Colvin</b>		13b. MOTHER'S MAIDEN NAME <b>Felicia Files</b>		14. NAME OF HUSBAND OR WIFE <b>Tom Hyatt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <b>no</b> unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Tom Hyatt, Odessa, 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>Chronic Lymphocytic Leukemia?</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) <b>—</b>
DUE TO (c) <b>—</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cardiac Insufficiency 2040</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 <b>1:20</b> Month, Day, Year <b>AM</b> 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 <b>10-17-58</b> to <b>12-26-58</b> and last saw her alive on <b>12-25-58</b> Death occurred at <b>1:20 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Lecil L. Watson, M.D.</b>			22b. ADDRESS <b>Odessa, Mo.</b>		22c. DATE SIGNED <b>12-29-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 28, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenton Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>4 Mi. N. of Odessa, Mo.</b>	
24. FUNERAL DIRECTOR <b>Husman-Sparks, Odessa, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12/30/1958</b>	26. REGISTRAR'S SIGNATURE <b>Emma Davidson</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Secretary, Missouri State Health Department, St. Louis, Mo. All diseases in Part I must be causally related. NO symptoms were reported.

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 *William G. Sparks* .....  
Licensed Embalmer No. *4431* .....  
P. O. Address *Edessa* .....

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.