

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046892

STATE FILE NUMBER

FILED DEC 24 1958

Registration District No. 338

Primary Registration District No. 3074

Registrar's No. 238

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-57

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Sikeston</u> TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Gray Ridge</u> <u>10 30 0</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Delta Comm. Hosp.</u>		Length of stay in 1b <u>6 Days</u>	d. STREET ADDRESS (If outside, give location) <u>—</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JACK</u> Middle <u>WILLIAM</u> Last <u>HILL</u>			4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1958</u>		
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5. SEX <u>Male</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>2-22-1911</u>	9. AGE (In years birth day) <u>47</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Arkansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>J. A. Hill</u>	13b. MOTHER'S MAIDEN NAME <u>Etta Wiley</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Imo Throop, Sikeston, Mo.</u> Address
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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>GAS GANGRENE, left leg, thigh & Buttocks</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>about 12 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Trauma to Perineum</u>	
	DUE TO (c) <u>063X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Left thigh ^{leg} amputation of left thigh & Debridement of Buttocks</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" 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.) <u>Buttocks began butting while driving a tractor on farm</u>
20c. TIME OF INJURY Hour <u>—</u> Month <u>—</u> Day <u>—</u> Year <u>—</u> a.m. <u>—</u> p.m. <u>about 11/28/58</u>	

20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>FARM</u>	20f. CITY, TOWN, OR LOCATION <u>Sikeston</u>	COUNTY <u>Scott</u>	STATE <u>MO.</u>
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21. I attended the deceased from <u>12/7/58</u> to <u>12/10/58</u> and last saw her alive on <u>12/10/58</u> Death occurred at <u>9:45 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Max A. Fleet M.D.</u>	22b. ADDRESS <u>Sikeston, Mo.</u>	22c. DATE SIGNED <u>12/11/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>12-12-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Sikeston, Mo.</u>
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24. FUNERAL DIRECTOR <u>Adelbertson Funeral Home</u> <u>Sikeston, Mo.</u>	ADDRESS <u>Sikeston, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-18-58</u>	26. REGISTRAR'S SIGNATURE <u>Max A. Fleet</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *Raymond L. Duffie*

Licensed Embalmer No. *4798*

P. O. Address *Berine, Mo.*

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.