Health,
& Welfare
Public
Service

300
1-57.

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000198
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 12

1. PLACE OF DEATH
a. COUNTY: Boone
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Columbia — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Univ. of Missouri medical center — Length of stay in 1b: 41 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Dallas
c. CITY OR TOWN: Buffalo — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): East Star Route — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: William Middle: Carlyle Last: Haden

4. DATE OF DEATH: Month: 1 Day: 4 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-27-1883

9. AGE (In years last birthday): 75 — IF UNDER 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): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (City and state or country): 9

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Robert Haden

13b. MOTHER'S MAIDEN NAME: Maggie Jennings

14. NAME OF HUSBAND OR WIFE:

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: Hospital Record — Address: University Hospital

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE, DECOMPENSATED
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
UREMIA DUE TO CHRONIC NEPHRITIS 4200

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 11/17/58, to 1/4/59 and last saw ~~him~~ him alive on 1/3/59
Death occurred at 445 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. S. Sanders MD

22b. ADDRESS: University Med Center

22c. DATE SIGNED: 1/5/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE: January 6, 1959

23c. NAME OF CEMETERY OR CREMATORY: Univ. Medical Center

23d. LOCATION (City, town, or county) (State): Columbia, Missouri

24. FUNERAL DIRECTOR ADDRESS: M. D. Overholser Dept. of Anatomy U. of Mo.

25. DATE RECD. BY LOCAL REG.: Jan 6 1959

26. REGISTRAR'S SIGNATURE: Mrs. R. E. Palmer

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was not embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student ..... Signature of Student Embalmer

Signed .....

Licensed Embalmer No.....

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.