

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

05-000601

STATE FILE NUMBER

FILED FEB 2 1959 Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 12

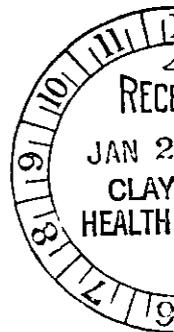
1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Benton	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Excelsior Springs, Mo.		c. CITY OR TOWN Decatur	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR VA CONSOLIDATED CENTER INSTITUTION Excelsior Springs		d. STREET ADDRESS (If outside, give location) Route 1	
3. NAME OF DECEASED (Type or print) First HARRY Middle A. Last HOOK		4. DATE OF DEATH Month Jan. Day 22 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Common	11. BIRTHPLACE (City and state or country) Sylvia, Kansas
13a. FATHER'S NAME James Hook		13b. MOTHER'S MAIDEN NAME Lizzie Steinbrink	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address VA Hospital records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis, pulmonary, far advanced, active DUE TO (b) Pulmonary Emphysema DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) (1) Duodenal ulcer, chr. (2) Myocarditis, chr., with decompensation			INTERVAL BETWEEN ONSET AND DEATH 18 years 13 Months
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. Attended the deceased from 7/30/58 to 1/22/59 Death occurred at 5:50 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE C. V. KERN (Degree or title) M.D.		22b. ADDRESS Excelsior Springs, Mo.	
22c. DATE SIGNED 1/23/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-26-59	
23c. NAME OF CEMETERY OR CREMATORY WADSWORTH CEMETERY		23d. LOCATION (City, town, or county) (State) WADSWORTH, KANSAS	
24. FUNERAL DIRECTOR Prichard Funeral Home, Inc.		25. DATE RECD. BY LOCAL REG. 1-26-59	
26. REGISTRAR'S SIGNATURE Baroline Nutting			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc.: must use only stenciled nomenclature in their 18. Year's symptoms with no other. All diseases in Part I must be causally related.

P.S.



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 *Ralph Van Landingham*

Licensed Embalmer No. *4009*
P. O. Address *Clayton Springs, Md.*

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.