

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006693
STATE FILE NUMBER

FILED MAR 6 1959 Registration District No. 276 Primary Registration District No. 5945 Registrar's No. 3

300
1-57

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Phelps	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Dillon		c. CITY OR TOWN Rolla	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Route 1.		d. STREET ADDRESS (If outside, give location) Route 1, Rolla Mo.,	
3. NAME OF DECEASED (Type or print) WILLIAM ANDREW HANCE		4. DATE OF DEATH Month Feb. Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timber & Tie Buyer		10b. KIND OF BUSINESS OR INDUSTRY Wood Industry	11. BIRTHPLACE (City and state or country) Phelps County, Mo.,
13a. FATHER'S NAME William A. Hance		13b. MOTHER'S MAIDEN NAME Caroline Tucker	12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No XX		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Albert Mueller, Rolla, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vasculo accident			INTERVAL BETWEEN ONSET AND DEATH 3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) .331y			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 _____ 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 11/30/58 to Feb 27, 1959 and last saw her/him alive on Feb 26, 1959 Death occurred at 5:20AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Dr. Anderson		22b. ADDRESS Rolla, Mo.	
		22c. DATE SIGNED 2/2/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 1, 1959	
23c. NAME OF CEMETERY OR CREMATORY Pilman Cemetery		23d. LOCATION (City, town, or county) (State) Near; Newburg, Mo.,	
24. FUNERAL DIRECTOR Null & Sons Funeral Home		25. DATE RECD. BY LOCAL REG. Rolla, Mo., 3-5-59	
		26. REGISTRAR'S SIGNATURE Ruth B. Powell	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

E.B.H.

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

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.