

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009062

STATE FILE NUMBER

FILED APR 6 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 338

300
1-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Montana b. COUNTY Big Horn	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kirby 8 25 8 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Medical Center for Federal Prisoners		Length of stay in 1b 47 days	d. STREET ADDRESS (If outside, give location) Unknown Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Willis Middle (NMN) Last Hisbadhorse			4. DATE OF DEATH Month March Day 28 Year 1959
5. SEX Male ♀	6. COLOR OR RACE Indian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1897
9. AGE (In years) 61 (at birthday)		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) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (City and state or country) Lamedeer, Montana
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Richard Hisbadhorse	
13b. MOTHER'S MAIDEN NAME Rhoada Hisbadhorse		14. NAME OF HUSBAND OR WIFE Widowed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT File - MCFP Springfield, Missouri Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tracheal obstruction			INTERVAL BETWEEN ONSET AND DEATH 10 minutes
DUE TO (b) Carcinoma of the Thyroid			5 years
DUE TO (c) Pulmonary metastases			(2 years)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 194X			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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. I attended the deceased from The Medical Staff 2-10-59 to 3-28-59 and last saw ^{her} _{him} alive on 3-28-59		Death occurred at 6:40 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>J. A. Hunter</i>		(Dr. or other) J. A. HUNTER, M.D. Clinical Director	22b. ADDRESS Medical Center for Federal Prisoners, Springfield, Mo.
22c. DATE SIGNED 3-30-59		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 4-1-59		23c. NAME OF CEMETERY OR CREMATORY Unknown	23d. LOCATION (City, town, or county) (State) Montana
24. FUNERAL DIRECTOR AYRE-GOODWIN:		ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 4-3-59
26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 16. No symptoms with be listed. All diseases in Part I must be causally related.

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 *Paul Lee me Law*

Licensed Embalmer No. *4232*
P. O. Address *Augusta Ga*

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.