

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012699

STATE FILE NUMBER

MAY 4 1959 Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 235

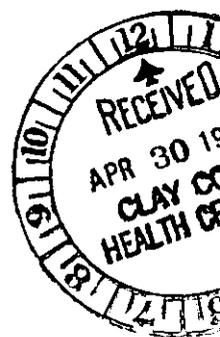
300
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Ray</u> <u>Clay</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN <u>Excelsior Springs</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>RR#1</u> | | Length of stay in 1b <u>83 years</u> | | d. STREET ADDRESS <u>RR#1</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>William Gill Hurt</u> | | | | 4. DATE OF DEATH Month Day Year <u>April 13, 1959</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 25, 1876</u> | | 9. AGE (In years last birthday) <u>83</u> | |
| 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>Lawson, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13a. FATHER'S NAME <u>John William Hurt</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Isabelle Jackson</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Lela Dagley</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>500-40-4951</u> | | 17. INFORMANT Address <u>Mrs. W. G. Hurt, Excelsior Springs, Mo.</u> | | | |
| 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>Cerebral hemorrhage</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis</u> | | | | | | | |
| DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral hemorrhage 1956 331x</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u>May 1955</u> , to <u>13 Apr 1959</u> and last saw <u>him</u> alive on <u>4-2-59</u> . Death occurred at <u>6:15 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>George E Anderson M.D.</u> | | | | 22b. ADDRESS <u>Excelsior Springs, Mo.</u> | | 22c. DATE SIGNED <u>4-14-59</u> | |
| 23a. BURIAL, CREMATION, BENEFIT (Specify) <u>Burial</u> | | 23b. DATE <u>4-15, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo.</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Prichard Funeral Home, Inc. Excelsior Springs, Missouri</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>4-20-59</u> | | 26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u> | |

MA. - 4 1958



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 *Lindell Jarman*

Licensed Embalmer No. *4589*
P. O. Address *Excelsior Springs, 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.