

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013695

STATE FILE NUMBER

FILED MAY 8 1959

Registration District No. 150

Primary Registration District No. 4240

Registrar's No. 109

|   |                                   |   |   |  |   |
|---|-----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY Jackson  |                                   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo<br>b. COUNTY Jackson |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN Blue Springs   |                                   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN Blue Springs  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION 808 S Zaun   |                                   | Length of stay in lb<br>4 yrs   | d. STREET ADDRESS (If outside, give location)<br>808 Zaun   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Otis M Hiatt  |                                   |   | 4. DATE OF DEATH<br>Month Day Year<br>April 25 1959   |  |   |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>Wh            | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Sept 27 1869  | 9. AGE (In years last birthday) 89<br>IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min. |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired Farmer   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br>Springdale Kan  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |
| 13a. FATHER'S NAME<br>Benjamin Hiatt  |                                   | 13b. MOTHER'S MAIDEN NAME<br>Martha Wilson  |   | 14. NAME OF HUSBAND OR WIFE<br>Mattie Hiatt  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>no   |                                   | 16. SOCIAL SECURITY NO.<br>None   | 17. INFORMANT<br>Mrs Arnold York 808 Zaun B.S Mo<br>Address   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute cardiac failure</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) <u>arterial sclerotic heart disease</u><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>_____ |                                   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 yr +</u>                                     |
| 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.)<br><u>4200</u>   |   |  |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.   |                                   |   |   |  |   |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>1-14-56</u> to <u>4-25-59</u> and last saw <sup>her</sup> him alive on <u>4-24-59</u><br>Death occurred at <u>2:30 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.  |                                   |   |   |  |   |
| 22a. SIGNATURE (Degree or title)<br><u>Merrill B. Bay M.D.</u>  |                                   |   | 22b. ADDRESS<br><u>Blue Springs, Mo</u>   |  | 22c. DATE SIGNED<br><u>4-25-59</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   | 23b. DATE<br><u>April 28 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Kogher Cem</u>   |   | 23d. LOCATION (city, town, or county) (State)<br><u>LaFontaine Kan</u>                                 |   |
| 24. FUNERAL DIRECTOR<br><u>Webb Funeral Home Blue Springs Mo</u>  |                                   | 25. DATE RECD. BY LOCAL REG.<br><u>4-28-59</u>  | 26. REGISTRAR'S SIGNATURE<br><u>M. B. Langford</u>  |  |   |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAY 20 1959

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 William Frew

Licensed Embalmer No. 4733

P. O. Address Blue Springs

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.