

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018398

STATE FILE NUMBER

FILED JUN 1 1959 Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 80

1. PLACE OF DEATH a. COUNTY <i>Macon</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Macon</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Macon</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>New Cambria</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Samaritan Hosp.</i>		Length of stay in 1b <i>5 days</i>	d. STREET ADDRESS (If outside, give location) <i>0610</i>
			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>SIMON HUGHES</i>			4. DATE OF DEATH Month Day Year <i>May 20, 1959</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 8, 1889</i>		9. AGE (In years last birthday) <i>70</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i>	11. BIRTHPLACE (City and state or country) <i>New Cambria, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>

13a. FATHER'S NAME <i>David J. Hughes</i>	13b. MOTHER'S MAIDEN NAME <i>Mary Ann Davis</i>	14. NAME OF HUSBAND OR WIFE <i>Jessie Cress Hughes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO. <i>492-28-1679</i>	17. INFORMANT <i>Mrs. Jessie Hughes, 1836 S. 44<sup>th</sup> Street, Kansas City, Mo.</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Hydatid. Pneumonia</i>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Chronic Myocardial Insufficiency</i> DUE TO (c) <i>Chronic Pulmonary Emphysema</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>5271</i>			

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
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21. I attended the deceased from *Mar 10, 1959* to *May 20, 1959* and last saw him alive on *May 20, 1959*  
Death occurred at \_\_\_\_\_ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>John A. Padden M.D.</i>	22b. ADDRESS <i>12221 Mission</i>	22c. DATE SIGNED <i>5/21/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>May 22, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New Cambria</i>	23d. LOCATION (City, town, or county) (State) <i>New Cambria, Mo.</i>
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24. FUNERAL DIRECTOR <i>H. J. Hilleland</i>	ADDRESS <i>New Cambria Mo</i>	25. DATE RECD. BY LOCAL REG. <i>May 21, 1959</i>	26. REGISTRAR'S SIGNATURE <i>Keith McNeely</i>
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(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service  
300  
-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  
MEDICAL CERTIFICATION

JUN 1 1959

Date Filed 5-29-59

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 *H. J. Lilleland* .....

Licensed Embalmer No. *4019* .....  
P. O. Address *New Columbia* .....

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.