

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020453

FILED JUN 22 1959

Registration District No. 042 Primary Registration District No. 1000 STATE FILE NUMBER Registrar's No. 622

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Missouri b. COUNTY Clinton	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Plattsburg
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hospital		Length of stay in lb 1 day	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Harvey E. Hall			4. DATE OF DEATH Month Day Year June 12 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6 1878
9. AGE (In years last birthday) 80	10. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) Retired	10b. KIND OF BUSINESS OR CARPENTER	11. BIRTHPLACE (City and state or country) Flag Springs, Missouri
12. CITIZEN OF WHAT COUNTRY? U S A	13a. FATHER'S NAME William Hall	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Nettie Hall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, unknown) (If yes, give No or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Fred Hall 1124 East 44 K.C. 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 vascular accident Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral vascular Thrombosis DUE TO (c) Cerebral arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X			INTERVAL BETWEEN ONSET AND DEATH 2-3 days 2-3 Days 4 years. 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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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 6/12/59, to 6/12/59 and last saw him alive on 6/12/59 Death occurred at 7:50 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (D, M, or title) Caryl A. Potter, M.D.		22b. ADDRESS Ply. St. Joseph, Missouri	22c. DATE SIGNED 6-13-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE June 12 1959	23c. NAME OF CEMETERY OR CREMATORY Floral Hills	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Floral Hills Memorial Chapel Inc K. C. Mo		25. DATE RECD. BY LOCAL REG. June 13 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

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.

Dr. Caryl A. Potter, M.D. - USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

*Dr. P. L. ...  
Dr. S. ...*

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 *Forrest D. Coldenow*

Licensed Embalmer No. *4714*  
P. O. Address *K. C. 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.