

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024415

FILED VS JUL 21 1959 53

Registration District No.

Primary Registration District No. 0000

Registrar's No. 251

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Cape Girardeau</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY <i>Cape Gir.</i>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Byrd</i>		Length of stay in 1b <i>75 yrs.</i>		c. CITY OR TOWN <i>Jackson R Mo.</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Jackson R mo</i>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>4 miles west Jackson</i>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <i>J W</i> Middle <i>Craig</i> Last <i>HUTSON</i>				4. DATE OF DEATH Month <i>July</i> Day <i>5</i> Year <i>1959</i>									
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</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>Oct 4, 1883</i>	9. AGE (last birthday) <i>75</i>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Min. _____						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeping</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (City and state or country) <i>Jackson Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>						
13a. FATHER'S NAME <i>J W Craig</i>			13b. MOTHER'S MAIDEN NAME <i>Martha Knott</i>			14. NAME OF HUSBAND OR WIFE <i>S.O. Hutson</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>✓</i>		17. INFORMANT Address <i>S.O. Hutson Jackson, MO</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>							INTERVAL BETWEEN ONSET AND DEATH <i>20 mins.</i>						
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <i>Coronary Artery Sclerosis</i>					DUE TO (c) _____		2 yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
19. WAS AUTOPSY PERFORMED? YES <input 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 _____ a.m. _____ p.m.		Month, Day, Year _____		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 <i>9-11-57</i> to <i>7-5-59</i> and last saw her ^{her} alive on <i>3-16-59</i> Death occurred at <i>5:40 a.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>J. N. Jaeger M.D.</i>				22b. ADDRESS <i>Jackson, Mo.</i>				22c. DATE SIGNED <i>7-7-59</i>					
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 7, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fairview</i>			23d. LOCATION (City, town, or county) (State) <i>Millersville, Mo.</i>							
24. FUNERAL DIRECTOR ADDRESS <i>S.C. Cracraft Jackson Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>7-16-1959</i>		26. REGISTRAR'S SIGNATURE <i>Drene Kasten</i>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Gene C. Cunniff*

Licensed Embalmer No. 432

P. O. Address Jackson

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.