

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-025784

STATE FILE NUMBER

FILED VS JUL 28 1959

X Registration District No. 174 Primary Registration District No. 5644 Registrar's No. 57

S. 300
1-57

3

1. PLACE OF DEATH a. COUNTY LAFAYETTE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY Lafayette	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington		c. CITY OR TOWN Lexington	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rural 5 miles South		d. STREET ADDRESS (If outside, give location) 14th. South St	
3. NAME OF DECEASED (Type or print) Ephriam Page Hyatt		4. DATE OF DEATH Month Day Year June 3 - 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		11. BIRTHPLACE (City and state or country) Odessa, Mo	
13a. FATHER'S NAME Ephriam Hyatt		14. NAME OF HUSBAND OR WIFE Ottie Hood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 499-094189	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Compound F-X left leg (Femur) DUE TO (b) ② Machine hemorrhage into pleural and peritoneal cavities DUE TO (c) ③ Shock. Lived a few minutes after the accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input checked="" 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.) Motor Car Collision	
20c. TIME OF INJURY Hour Month, Day, Year 11:45 a.m. 6-3-59		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hickory	
20e. CITY, TOWN, OR LOCATION Lexington		20f. COUNTY STATE Lafayette Mo	
21. I attended the deceased from not by recent years to 11-93 and last saw him alive on 1-2 years ago Death occurred at 11:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Wm. Martin M.D. Corona 3	
22b. ADDRESS Odessa Mo		22c. DATE SIGNED 6-3-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-5-59	
23c. NAME OF CEMETERY OR CREMATORY Machpelah		23d. LOCATION (City, town, or county) (State) Lexington, Mo	
25. FUNERAL DIRECTOR ADDRESS Genest & George Lexington		25. DATE RECD. BY LOCAL REG. 7-23-59	
26. REGISTRAR'S SIGNATURE Wm. E. Eastburn			

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

(Licensed Embalmer's Statement on Reverse Side)

AUG 1 1 1958

JUL 28 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 *Harriet J. Temple*

Licensed Embalmer No. *3275*

P. O. Address *Lyngton*

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.