

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026331

FILED VS AUG 11 1959

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. \_\_\_\_\_ Registrar's No. 311

DED

1. PLACE OF DEATH a. COUNTY <b>St. Francois;</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP OR TOWN) <b>Marion Township</b>	Length of stay in 1b <b>***</b>	c. CITY OR TOWN <b>Bonne Terre</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Residence.</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Rt. # 1</b>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>LEE BAKER HUTCHINGS</b>			4. DATE OF DEATH <b>August 6, 1959</b>		
First	Middle	Last	Month	Day	Year

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-2-1885</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>14</b>	IF UNDER 24 HR Hours <b>4</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Bonne Terre, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>John Baker Hutchings</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Feiling</b>	14. NAME OF HUSBAND OR WIFE <b>Bertha Mae Hutchings</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>***</b>	17. INFORMANT <b>Wife</b> Address <b>Rt. 1 Bonne Terre, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastric intestinal hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
DUE TO (b) <b>Chronic passive congestion</b>		5 years.
DUE TO (c) <b>Arteriosclerotic heart disease.</b>		
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 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.)
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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 _____
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21. I attended the deceased from 9/26/53 to 4/15/59 and last saw him xx alive on 4/15/59  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i> (Degree or title)	22b. ADDRESS <b>Bonne Terre, Missouri</b>	22c. DATE SIGNED <b>8/8/59</b>
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23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>	23b. DATE <b>8-9-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Francois Memorial.</b>	23d. LOCATION (City, town, or county) (State) <b>Bonne Terre, Mo.</b>
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24. FUNERAL DIRECTOR <b>C.Z. BOYER &amp; SON INC.</b> ADDRESS <b>Bonne Terre, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Aug. 8, 1959</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DR. MULLEN

**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 B. T. Boyer  
B. T. BOYER

Licensed Embalmer No. 3660

P. O. Address Desloge, 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.