

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-028342**

FILED VS AUG 18 1959

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 213

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in lb <u>1 mo. 3 das.</u>	c. CITY OR TOWN <u>Sedalia</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural Route</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>H.</u> Last <u>HOSTLER</u>			4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1959</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-1871</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>George W. Hostler</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Cornine</u>	14. NAME OF HUSBAND OR WIFE <u>unk.</u>
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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) <u>D.K.</u>	16. SOCIAL SECURITY NO. <u>D.K.</u>	17. INFORMANT <u>Dallas M. Mullin, Kansas City, Mo</u> Address _____
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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:		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>
IMMEDIATE CAUSE (a) <u>HYPOSTATIC PNEUMONIA</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>SENILITY</u>	
DUE TO (c) <u>CHRONIC BRAIN SYNDROME WITH SENILE BRAIN DISEASE</u>		

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
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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 _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>St. Hosp. #1</u>	COUNTY _____ STATE _____
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21. x attended the deceased from July 8, 1959 to August 11, 1959  
Death occurred at 11:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H. G. Freund M.D.</u> (Degree or title)	22b. ADDRESS <u>State Hospital #1; Fulton, Mo.</u>	22c. DATE SIGNED <u>8-12-59</u>
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23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug. 14-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>
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24. FUNERAL DIRECTOR <u>D W Hechart</u> ADDRESS <u>Sedalia Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Aug-12-1959</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1959 AUG 18

**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 D. W. Keckart

Licensed Embalmer No. 3470

P. O. Address Sedalia

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