

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-028343

FILED VS SEP 2 1959

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 229

STATE FILE NUMBER

DED

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> COUNTY <u>RANDOLPH</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>25 yrs.</u>	c. CITY OR TOWN <u>MOBERLY</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>State Hospital No. 1</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MELVIN</u> Middle _____ Last <u>HURT</u>			4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1959</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (last birthday) <u>68 ???</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>Hostler helper at Wabash Shops</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shops</u>	11. BIRTHPLACE (City and state or country) <u>Howard County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Jack Hurt</u>		13b. MOTHER'S MAIDEN NAME <u>Maria Hughes</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Dorothy Hurt</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, in or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>State Hospital No. 1, Fulton, Mo.</u>
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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) <u>Carcinoma of the lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 <u>St. Hosp.</u>	COUNTY <u>Callaway</u>	STATE <u>Mo.</u>
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21. <input checked="" type="checkbox"/> attended the deceased from <u>May 25, 1934</u> to <u>8-28-1959</u> and last saw her/him alive on _____ Death occurred at <u>8-28-1959</u> <u>3:45</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>Martha Lawrence M.D.</u>	22b. ADDRESS <u>State Hospital No. 1</u>	22c. DATE SIGNED <u>8-28-59</u>
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23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23a. DATE <u>Sept. 1-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Roanoke Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Roanoke Mo</u>
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24. FUNERAL DIRECTOR <u>Waller Funeral Home, Fulton Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Aug. 29-1959</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 9 1959

SEP 23 1959

**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 Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address Fullon,

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.