

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031935

FILED VS OCT 2 1959

STATE FILE NUMBER

 Registration District No. 114 Primary Registration District No. 4186 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MERAMEC</u>		Length of stay in 1b <u>3 mos.</u>	c. CITY OR TOWN <u>SULLIVAN</u>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.R. 2 SULLIVAN</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>R. R. # 2</u>
			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARK</u> Middle <u>EUGENE</u> Last <u>HANEY</u>			4. DATE OF DEATH Month <u>SEPT</u> Day <u>29</u> Year <u>1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-59</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>	IF UNDER 24 HR Hours <u>3</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>SULLIVAN, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>

13a. FATHER'S NAME <u>DONALD E. HANEY</u>		13b. MOTHER'S MAIDEN NAME <u>MARY ANN HETHINGTON</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>DONALD E. HANEY R.R. 2 SULLIVAN MO.</u>	

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>PNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</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.)
--	---	--

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 JUNE 26-1959 to SEP 29 59 and last saw ^{him} ~~her~~ alive on AUGUST 1959
Death occurred at 8:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert Thompson</u> (Degree or title) <u>MO</u>	22b. ADDRESS <u>Sullivan, Missouri</u>	22c. DATE SIGNED <u>Sept 30-59</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-1-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. MEMORIAL CEM. SULLIVAN, MO.</u>	23d. LOCATION (City, town, or county) (State) _____
---	--------------------------	--	---

24. FUNERAL DIRECTOR <u>H. M. EATON</u> ADDRESS <u>SULLIVAN, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>9-30-59</u>	26. REGISTRAR'S SIGNATURE <u>T. A. Humphrey</u>
--	---	---

(Licensed Embalmer's Statement on Reverse Side)

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 Thermon W. Eaton

Licensed Embalmer No. 5066

P. O. Address Sullivan,

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.