

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035184

FILED VS OCT 26 1959 38

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 3006 Registrar's No. 505

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Shelby</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>2 mo.</u>		c. CITY OR TOWN <u>Shelbina</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kelly Warren Hines</u>				4. DATE OF DEATH Month Day Year <u>October 20, 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>6/30/59</u>		9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months <u>3</u> Days <u>20</u> Hours _____ 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>Macon, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Robert Lee Hines</u>			13b. MOTHER'S MAIDEN NAME <u>Gladys Irene Hawkins</u>			14. NAME OF HUSBAND OR WIFE -----			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Robert L. Hines</u>		Address <u>Shelbina, 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>Anoxia</u>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.		DUE TO (b) <u>Congenital Heart Disease - USD And VASCULAR Ring</u>							
		DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>10 hours Post-OP</u>						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 checked="" type="checkbox"/> NO <input 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 <u>September 1, 1959</u> to <u>October 20, 1959</u> and last saw her/him alive on <u>10/20/59</u> . Death occurred at <u>2:35 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Ray August Westafeld M.D.</u>				22b. ADDRESS <u>Univ. of Mo. Med Center</u>			22c. DATE SIGNED <u>10/20/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/21/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Shelbina Cemetery</u>		23d. LOCATION (City, town, or county) <u>Shelbina, Missouri</u>			
24. FUNERAL DIRECTOR <u>Hayes Funeral Home, Shelbina, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Oct 21 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>			

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 Jack Hayes

Licensed Embalmer No. 3699

P. O. Address Shelburne

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.