

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041479

FILED VS. NOV. 17 1959 3/6

Registration District No. Primary Registration District No. Registrar's No. 430

STATE FILE NUMBER

ENDED

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 only) OR TOWN <b>FLAT RIVER</b>		Length of stay in 1b		c. CITY OR TOWN <b>LEADINGTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>KILLED ON HWAY 67</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>HWAY 67</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>DANIEL</b> Last <b>HABLE</b>				4. DATE OF DEATH Month <b>NOV</b> Day <b>10</b> Year <b>1959</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 5 1949</b>	9. AGE (last birthday) <b>10</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13a. FATHER'S NAME <b>EDWARD J. HABLE</b>			13b. MOTHER'S MAIDEN NAME <b>LORRAINE Thontant HABLE</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>			
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>NONE</b>		17. INFORMANT <b>EDWARD J. HABLE LEADINGTON</b> Address			
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>Skull Fracture and Multiple injuries</b> DUE TO (b) <b>Coroner Jury Verdict: due to injuries received</b> DUE TO (c) <b>by automobile in unavoidable accident</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" 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.) <b>Injuries received in accident.</b>						
20c. TIME OF INJURY Hour <b>3:45</b> p.m. Month <b>11</b> Day <b>10</b> Year <b>1959</b>								
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.) <b>Public Highway</b>		20f. CITY, TOWN, OR LOCATION <b>Leadington</b>		COUNTY <b>St. Francois Mo.</b>	STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Becky Miller</b> (Degree or title) <b>Coroner</b>				22b. ADDRESS <b>Farmington, Mo</b>		22c. DATE SIGNED <b>11/12/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>NOV 13, 1959</b>	23c. NAME OF CEMETERY OR CREMATION <b>PARKVIEW CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>NEAR FARMINGTON, MO.</b>			
24. FUNERAL DIRECTOR <b>B. CALDWELL + SON'S</b> ADDRESS <b>74 EAST MAIN ST.</b>			25. DATE RECD. BY LOCAL REG. <b>NOV. 12, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Ether Rudloff</b>			

FLAT RIVER. (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 me  
or by Donald Dale Caldwell Student Embalmer No. 587

working under my personal supervision.

Student Donald Dale Caldwell Signed R. Caldwell  
Signature of Student Embalmer

Licensed Embalmer No. 2531

P. O. Address Flat River, Va.

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.