

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-50-000519
60-000519
STATE FILE NUMBER

FILED VS FEB 3 1960 47

Registration District No. _____ Primary Registration District No. 3008 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Callaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fulton		Length of stay in 1b Years	c. CITY OR TOWN Fulton Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 303 Short St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 303 Short St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Ernest Middle Caulfield Last Hogg	4. DATE OF DEATH Month January Day 22 Year 1960
---	---

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5 June 1878	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
--------------------	-------------------------------	---	-------------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Common Labor	11. BIRTHPLACE (City and state or country) Buglawton, England	12. CITIZEN OF WHAT COUNTRY USA
---	--	---	---

13a. FATHER'S NAME Capel Wilson Hogg	13b. MOTHER'S MAIDEN NAME Harriette Robinson	14. NAME OF HUSBAND OR WIFE Unknown
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 489 20 0448	17. INFORMANT Address Information from Cert. Copy Birth
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma tongue & metastases to neck.		INTERVAL BETWEEN ONSET AND DEATH 1 year
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 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 **Jan 1959** to **Dec 1959** and last saw her/him alive on **Dec. 12, 1959**
Death occurred at **2:09 PM** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (D, M.D. or title) George W. Groe, M.D.	22b. ADDRESS Fulton, Mo.	22c. DATE SIGNED 1-29-60
--	------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Anatomical Board	23b. DATE 1-23-60	23c. NAME OF CEMETERY OR CREMATORY State Anatomical Board	23d. LOCATION (City, town, or county) (State) Columbia, Missouri
--	-----------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS Morgan Funeral Home, Fulton, Mo.	25. DATE RECD. BY LOCAL REG. Jan. 30 - 1960	26. REGISTRAR'S SIGNATURE Martha Lawrence
---	---	---

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 Marshall C. Blackwell

Licensed Embalmer No. 4710

P. O. Address Fulton, N.C.

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.