

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007848

FILED VS MAR 8 1960 316

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 87

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Crawford					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township		Length of stay in lb 7Mo. 27das.		c. CITY OR TOWN Sullivan		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital No. 4			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Unknown		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First RACHEL Middle ANNA Last HIXON				4. DATE OF DEATH Month February Day 20 , Year 1960					
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12-7-1898	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months 2 Days 13 Hours Min. 		IF UNDER 24 HR Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Salina, Kansas		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME William Randolph			13b. MOTHER'S MAIDEN NAME Sanburn			14. NAME OF HUSBAND OR WIFE Carl Hixon			
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. None		17. INFORMANT Records, State Hospital No. 4, Farmington, Mo.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized and marked - - -							INTERVAL BETWEEN ONSET AND DEATH 4 years.		
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) Chronic brain syndrome associated with circulatory disease with psychotic reaction.						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 Sullivan		COUNTY Missouri		STATE Missouri	
21. I attended the deceased from June 23, 1959 to Feb. 20, 1960 and last saw him live on Feb. 20, 1960 Death occurred at 5:40 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS State Hospital No. 4 Farmington, Missouri			22c. DATE SIGNED 2-23-60 (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 23, 1960	23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION (City, town, or county) Sullivan, Missouri				
24. FUNERAL DIRECTOR Shafer Funeral Home, Sullivan, Missouri			ADDRESS		25. DATE RECD. BY LOCAL REG. Feb. 23, 1960		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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 Paul K. Dugal

Licensed Embalmer No. 4120

P. O. Address Farmington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.