

STATE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. APR 12 1960

53

Primary Registration District No. 3010

Registrar's No. 147

60-010170

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Cape Girardeau		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cape Girardeau	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau		c. CITY OR TOWN Jackson Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR RESIDENCE Southeast Mo. Hospital doa Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 518 Michael Anna Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Warren Middle Hale Last Hale			4. DATE OF DEATH Month Mar Day 26 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/6/1891	9. AGE (last birthday) 69	IF UNDER 1 YEAR IF UNDER 24 HR Months Days 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 Brick Plant		11. BIRTHPLACE (City and state or country) Hawk Eye Iowa		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Warren Hale		13b. MOTHER'S MAIDEN NAME Josephine McClard		14. NAME OF HUSBAND OR WIFE Elva Hale		
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. 489-03-0888		17. INFORMANT Address Elva Hale 518 Michael Anna		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Coronary thrombosis		
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 checked="" 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 **Aug. 15th, 1951** to **July 3rd, 1959** and last saw him alive on **July 3rd, 1959**
 Death occurred at **March 26th, 1960 4:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Albert B. Tindall, D.O.</i>		22b. ADDRESS Jackson, Missouri	22c. DATE SIGNED 4/7/60
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/28/60	23c. NAME OF CEMETERY OR CREMATORY Iona Cemetery	23d. LOCATION (City, town, or county) (State) Jackson Rt. Missouri
24. FUNERAL DIRECTOR <i>A.C. Cough</i> Jackson, Missouri		25. DATE RECD. BY LOCAL REG. 4-7-60	26. REGISTRAR'S SIGNATURE <i>Dennis Kasten</i>

(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 *Gene O'Connell*

Licensed Embalmer No. 4927

P. O. Address *Johnston*

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.